CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

VP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. If available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, na additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B.	C.
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrop or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force 3/28/63
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DE[illegible] OF BALTIMORE

E 53001

E 53001

49

REGISTERED NO.

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 1100 E. Fayette St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Freda May Woods

(a) RESIDENCE NO. 1100 E. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William Woods

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE 41	Years	Months	Days	IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant William Woods
(Address) 22 E. East Street

15 FILED 19 Registrar

N 5 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis with
Lung Involvement
Duration) 2 Some time yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William McKernon M. D.

Jan 14 1930 (Address) 1637 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvery Cem.

DATE OF BURIAL: 1-15 1930

20 UNDERTAKER: Byron Knight 1218 McCulloh St

ADDRESS

Spec.—2-21-29—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53002

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ____ ST. 22-6 WARD)

REGISTERED NO. 1221 E 53002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E. Spurry

(a) RESIDENCE NO. Williams St. nr. Key Highway ST., ____ WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Martin Spurry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of Balto. City Hospitals (Address)

15 Filed JAN 15 1930 16 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-12-30

17 I HEREBY CERTIFY, That I attended deceased from 1-6-30, 19__, to 1-12-30, 19__, that I last saw him alive on 1-12-30, 19__, and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver over

Myocarditis, Chronic over

(duration) over 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhages from Nose

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1-8-30

Was there an autopsy? Yes

What test confirmed diagnosis? Wass. P.C. Lab. X-ray Autopsy

(Signed) Marvin M. McLean, M. D.

1-14, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W S NATIONAL BALTO

DATE OF BURIAL 1/16 1930

20 UNDERTAKER Robert Brookerson

ADDRESS CALHOUN & HOLLINS ST

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

18-002

E 53003

CERTIFICATE OF DEATH

E 53003

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital, WARD) REGISTERED NO. 59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma [redacted] Foster

(a) RESIDENCE NO. 2422 Stockton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Foster

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer gno Hess.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Hoy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) am Negress

12 MAIDEN NAME OF MOTHER Mary Hoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William Foster (Address) 2422 Stockton st

15 Filed Jan 15, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-13-30

17 I HEREBY CERTIFY, That I attended deceased from 1-7-, 1930, to 1-13-, 1930 that I last saw her alive on 1-13-, 1930 and that death occurred, on the date stated above, at 705 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Obstruction

Cerebral Hemorrhage

Laceration Bowel

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1-2-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. J. Jackson M. D.

1-13, 1930 (Address) 600 Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery DATE OF BURIAL Jan 16 1930

20 UNDERTAKER Ernest Bree ADDRESS 1129 W Hemmeter st

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 53004

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 S. Charles St. ST. 23-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julius F. Sass

(a) RESIDENCE NO. 1614 S. Charles St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Sass

6 DATE OF BIRTH (month, day, and year) Feb. 1 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Julius F. Sass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Wildt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary A. Sass

(Address) 1614 S. Charles St

Filed APR 15 1930 H. A. [illegible] M. D. Registrar

Rec'd [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10 1930 to Jan 14 1930, that I last saw h[illegible] alive on Jan 13. 1930 and that death occurred, on the date stated above, at 1 45 A m.

The CAUSE OF DEATH* was as follows:

Senile Arteriosclerosis

(duration) yrs. 6 mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. Hall Turner M. D.

1-15-30 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 1/16 1930

20 UNDERTAKER J. Fenw. McCully

ADDRESS 1306 E. Fort

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53005

CERTIFICATE OF DEATH.

31 E 53005

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2129 Annapolis ave St., 25th WARD

2-FULL NAME Harry Lee French

(a) RESIDENCE NO. 2129 Annapolis Ave St., 25th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widower.

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of late Louisa French.

6 DATE OF BIRTH (month, day, and year) March 24 1876

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
53	9	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Elevator construction

(c) Name of employer Otarsaw Elevator Co

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Samuel W French

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Jemima R Cobb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass

14 Informant Mrs Charlotte French.
(Address) 2129 Annapolis Ave.

15 Filed JAN 15 1930 19 RHM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Jan 14, 1930.

that I last saw h alive on Jan 13, 1930.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis Laryngitis.

(duration) 2 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas W Wheeler M. D.

1/14, 1930 (Address) 2410 Collins Ferry Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery | DATE OF BURIAL Jan 17 1930

20 UNDERTAKER Charles H Kahler | ADDRESS 532 Collins Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Name should be plainly supplied. AGE should be filled EXACTLY. PHYSICIANS should give

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53006 E 53006

CERTIFICATE OF DEATH.

REGISTERED NO. C 3-57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Childrens Hospital School St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Williams

(Residence in Baltimore: No. Eastern Ave. Road Essex Md. St.; 3 yrs., 6 mos. 14 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	white	Single

6-DATE OF BIRTH. Feb. 17 (Month) 1926 (Day), 1 (Year)

7-AGE.	If LESS than 1 day,
3 yrs. 11 mos. 17 da. (10 17)	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Essex Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER. Fredrik Williams

11-BIRTHPLACE OF FATHER (State or Country) Baltimore Co. Md.

12-MAIDEN NAME OF MOTHER. Margaret Koelber

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. K. Livingston M. D.

(Address) Childrens Hospital School

15- JAN 5 1930 C. HAMPSON JONES, M. D.

Reg. Pat

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 1 (Month) 14 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 1-1 1930, to 1-14 1930, that I saw h[illegible] alive on 1-14 1930, and that death occurred, on the date stated above, at 6-50 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

Following Tuberculosis

(Lungs)

(Duration) 0 yrs. 0 mos. 14 da.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(Duration) 0 yrs. 0 mos. 4 da.

(Signed) H. K. Livingston M. D.

1-14 1930 (Address) Childrens Hosp. School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yr. 6 mos. 0 da. In the State 3 yr. 11 mos. 17 da.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence Essex Md.

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oak Lawn	1-17, 1930
20-UNDERTAKER John J. Connelly	ADDRESS Cross

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53007

CERTIFICATE OF DEATH

12 1 V

E 53007

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospt. St. 13-57 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Sibley

(a) RESIDENCE NO. 1211 Jas. 40 the St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Sibley

6 DATE OF BIRTH (month, day, and year): May 7th - 1873.

7 AGE Years: 56 Months: 8 Days: 6

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: John H. Carter

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Hospital Records

(Address)

JAN 5 1930 H. HAMPSON GIBBS, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 1/13/30

17 I HEREBY CERTIFY, That I attended deceased from 1/5/30, 19..., to 1/13/30, 19...,

that I last saw h[illegible] alive on 1/13/30, 19...,

and that death occurred, on the date stated above, at 5 32 p.m.

The CAUSE OF DEATH* was as follows:

Empyema of Gall Bladder.

Status on Examination.

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary): Acute Dilatation of Heart.

(duration) yrs. mos. ? da.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? Yes Date of 1/5/30

Was there an autopsy? No.

What test confirmed diagnosis? Clinical -

(Signed) H. Kleinschmidt, M. D.

1/13, 1930 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvert

Date of Burial: Jan 16 1930

20 UNDERTAKER: Fred A. Fernandez

ADDRESS: 703 Hanover

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53008 ✓ 129 E 53008

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. University Hospital WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ceaser Burch

(a) RESIDENCE NO. Hughsville Md ST., ... WARD 4
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Burch

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None, dd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... JAMES [illegible], M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15/30

17 I HEREBY CERTIFY, That I attended deceased from 1/4 ....., 19 29, to 1/15 ....., 19 30,
that I last saw him alive on 1/13 ....., 19 30
and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied prostate & Chronic Cystitis. Nephritis. Uremia

(duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Cystoscopy & Pathological

(Signed) Luther [illegible], M. D.

19 ..... (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wash D.C. — DATE OF BURIAL Jan 1 1930

20 UNDERTAKER John Tillman — ADDRESS Cook Cake ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 53009

CERTIFICATE OF DEATH

E 53009

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 853 N. Lombard St) (Ward) 18-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Albert Walters.

(a) RESIDENCE NO. 853 N Lombard St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of Jennie A. Walters.

6 DATE OF BIRTH (month, day, and year) 6. 5. 1867.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	62	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 1062

(b) General nature of industry, business, or establishment in which employed (or employer) Picture Frame Factory

(c) Name of employer White & Siedenman Co.

9 BIRTHPLACE (city or town) Winchester

(State or country) Va

PARENTS

10 NAME OF FATHER Jeff Walters.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Wilbur F. Walters (Son)

(Address) 2037 N Fayette St

15 Filed JAN 15 1930 C. HARRISON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1930, to Jan 14, 1930,

that I last saw him alive on Jan 14. 1930,

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia.

(duration) 1 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. What test confirmed diagnosis? Physical Exam. Dr.

(Signed) Chas Norton, M. D.

1/14. 1930 (Address) 888 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rose Hill Hagerstown Md Date of Burial Jan 16 1930

20 UNDERTAKER Edw. G. Crook ADDRESS 1723 Pattpk Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 53010 E 53010

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 Park Avenue ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Jacobsen Gillet

(a) RESIDENCE NO. 1420 Park Avenue ST., WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 4 mos 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept-12-1862

7 AGE	Years	Months	Days ✓	If LESS than 1 day, hrs. or min.
	67	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George M. Gillet

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Antionette Jacobsen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. James McClure Gillet
(Address) 1420 Park Avenue

15 Filed ..... 19 ..... HAMILTON S. M. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14/30

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1928, to Jan 14, 1930, that I last saw h[illegible] alive on Jan 14, 1930 and that death occurred, on the date stated above, at noon m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. 1 ds.

CONTRIBUTORY (Secondary) Aortic stenosis & Hyper-tension (duration) 5 yrs. mos. ds.

18 Where was disease contrartrd if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. O. Hebart, M. D.

11/15, 1930 (Address) 1403 Park Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Nov. 16 1930

20 UNDERTAKER Stewart & Mowen Company — ADDRESS 108 W. North Ave.

Spec.—2-19-28—1. F. S.—500 Bks.

E 53011 ✓ E 53011

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 530T1 129

CERTIFICATE OF DEATH

REGISTERED NO. E 530T1

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 N. Belnord Ave STO-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Howard Keller

(a) RESIDENCE NO. 209 N. Belnord Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 6 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 2, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 060

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston Mass

12 MAIDEN NAME OF MOTHER Lucy McCuskey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. William Keller

(Address) 209 N. Belnord Ave

15 JAN 15 1930 19 RLH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-15-30

17 I HEREBY CERTIFY, That I attended deceased (from) 1-11 19 30 to 1-15 19 30

that I last saw him alive on 1-12 19 30

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows: Intracranial Diphtheria

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) acute Bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Smear

(Signed) Fred Burch M.D.

19 (Address) 600 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Jan 16, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St.

important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 53012

CERTIFICATE OF DEATH

E 53012

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Fisher

(a) RESIDENCE NO. Belair Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			one	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Belair, Md.

PARENTS

10 NAME OF FATHER: Jerry Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Minnie Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: R. G. Douglas

(Address) JOHNS HOPKINS HOSPITAL

15 JAN 5 1930 19 H. Ridgely Jones, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 28 1929

17 I HEREBY CERTIFY, That I attended deceased from 12-27, 1929, to 12-28, 1929

that I last saw h[illegible] alive on 12-28, 1929

and that death occurred, on the date stated above, at 4:00 A m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. G. Douglas, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS JAN 7 1930

Commissioner of Health.

important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 53013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 53013

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 116 h Luzerne Avenue ST.; 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Woelfel Woelfel J.L.W.

(a) RESIDENCE. NO. 116 h Luzerne Ave ST., WARD. 3-18-30

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of George Woelfel

6 DATE OF BIRTH (month, day, and year) 7/6/1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Edward Buthing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER E Buthing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Woelfel

(Address) 116 h Luzerne Avenue

Filed JAN 15 1930 19 H. [illegible] JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 29th, 1929, to Jan 13th, 1930

that I last saw her alive on , 1930

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Valvular Heart dis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Wimmer M. D.

1-14, 1930 (Address) 308 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	1/16 1930

20 UNDERTAKER George J Ruth ADDRESS 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53014 ✓ E 53014

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 12-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Frey

(a) RESIDENCE NO. 35 Hughes st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Frey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 JAN 15 1930 C. HAMILTON JONES, M. D. UNIVERSITY OF MARYLAND Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929, to Jan. 11, 1930, that I last saw h im alive on Jan. 11, 1930 and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thurnell M. D.

1-11 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER Commissioner Health

DATE OF BURIAL 19

ADDRESS JAN 15 1930

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53015

CERTIFICATE OF DEATH

90

REGISTERED NO. E 53015

1—PLACE OF DEATH Balto. City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1723 ST. (WARD)

2—FULL NAME Thomas Wright

(a) RESIDENCE NO. 1303 Upton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 2 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Ben. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records of

(Address) Balto. City Hospitals

15 1 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-10-30

17 I HEREBY CERTIFY, That I attended deceased from 1-9-30, 19..., to 1-10-30, 19...,

that I last saw him alive on 1-10-30, 19...

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Aortic Insufficiency; Hypertension; Arteriosclerosis (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Harvey W. McClean, M. D.

1-12, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	JAN 15 1930

20 UNDERTAKER Commissioner Health

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 53016 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53016

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 725 N. Chester St. ST., 7 | 13 (WARD)

2-FULL NAME Fortunata Cilento

(a) RESIDENCE NO. 725 N. Chester St ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Raphael Cilento

6 DATE OF BIRTH (month, day, and year) June 26 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
83 84	84	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Crapani

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Joseph Cilento

(Address) 725 N. Chester St

15 Filed JAN 15 1930 C. HAMPSON JONES, M. D. Registrar

Per ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 13 1930

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1930, to January 13, 1930, that I last saw h alive on January 13, 1930, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Ayd, M. D.

Jan 15, 1930 (Address) 2006 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL Jan. 16 1930

20 UNDERTAKER William G. Schaeffer ADDRESS 1816 Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

JAN 15 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53017

90

E 53017

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 S. Clinton ST., 26-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Schindhelm

(a) RESIDENCE NO. 1139 S. Clinton ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Schindhelm

6 DATE OF BIRTH (month, day, and year) Jan. 6th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Nicholas Baty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Schindhelm (Address) 1139 S. Clinton St.

15 Filed JAN 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Jan 13, 1930, that I last saw her alive on Jan 13, 1930 and that death occurred, on the date stated above, at 6 50 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Hance B. Tilton, M. D.

1/14, 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Jan. 16 1930
20 UNDERTAKER Lilly & Geiler Sts.	ADDRESS 403 S. Wolfe St

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53018 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 53018

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4301 Parkmount Ave ST. 26-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanislaus Samolinski

(a) RESIDENCE NO. 4301 Parkmount Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(r) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles P. Emshaiss
(Address) 4301 Parkmount ave

15 Filed JAN 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1930 to Jan 13 1930 that I last saw h... alive on Jan 13 1930 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
Emphysema

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

Jan 14 1930 (Address) 4 W Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan. 17 1930
20 UNDERTAKER	ADDRESS
Lilly & Feiler Inc.	403 S. Wolfe St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53019

CERTIFICATE OF DEATH

154-002

E 53019

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2707 Southern Ave ST. 47-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph E Wonnemann

(a) RESIDENCE NO. 2707 Southern Av ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-16-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	1 0	2 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Geo Wonnemann

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Pohl

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary Wonnemann
(Address) 2707 Southern Ave

15 Filed JAN 15 1930 C. HAMPSON JONES, M. D.
(Registrar) (Health Officer)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14.

17 I HEREBY CERTIFY, That I attended deceased from Dec 16 1929 to Jan 14 1930

that I last saw him alive on Jan 14 1930

and that death occurred, on the date stated above, at 9.50 a m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Disease

Acute Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. C. Richardson M.D.

1930 (Address) 1171 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jan 16 1930

20 UNDERTAKER Mary M Medford

ADDRESS 701 E 22nd St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53020

E 53020

CERTIFICATE OF DEATH

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL (REGISTERED NO. 5-45 45)

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Franklin C. Robinson

(a) RESIDENCE NO. 1658 Normal Ave. ST., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Christine Robinson

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 06

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alex Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eleanor Coore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... C. HAMPSON JONES, M. D. Registrar

N 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15/30

17

I HEREBY CERTIFY, That I attended deceased from 12/31, 1929, to 1/15, 1930, that I last saw him alive on 1/15/30, 19.. and that death occurred, on the date stated above, at 1221 m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

Tbc peritonitis?

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction, partial

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 1/14/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation, X-ray

(Signed) Fred W Sei[illegible], M. D.

, 19 The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 18 1930
UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 5302T

E 5302T

CERTIFICATE OF DEATH

31

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 N Wolfe ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Elizabeth Ackerman

(a) RESIDENCE NO. 1732 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 9 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos: ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not married

6 DATE OF BIRTH (month, day, and year) April 3, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Department Store

(c) Name of employer Stewart & Co.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Kundmiller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Catherine Ackerman

(Address) 1732 N. Wolfe St.

15 Filed JAN 15 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to January 17, 1930,

that I last saw her alive on January 12, 1930

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lungs.

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. A. F. Pfeffer, M. D.

1/14, 1930 (Address) 2934 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Interment Greenmount Cemetery	Jan 16 1930
20 UNDERTAKER Henry Lutz	ADDRESS 1283 N. Broadway

important: See instructions on back of certificates.

JAN 15 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 53022

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53022

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Stewart Easter

(a) RESIDENCE NO. 2310 Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Hamilton Easter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Agnes Cuttler

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country) Pennsylvania

14 Informant Patient

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

By

JAN 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1930, to January 15, 1930, that I last saw h[illegible] alive on January 15, 1930 and that death occurred, on the date stated above, at 7:20 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

Cardio-vascular renal disease

hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sphygmomanometer & P.E.

(Signed) Richard T. Blanchefond, M. D.

Jan 15, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Drummont

DATE OF BURIAL 1/17 1930

20 UNDERTAKER D. M. Cook

ADDRESS 1217 E. Pratt St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53023 ✓

E 53023

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST. 7-50 WARD

2-FULL NAME Sarah Margaret King

(a) RESIDENCE NO. Southern Hospital ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George M King

6 DATE OF BIRTH (month, day, and year) Sept 12-1844.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	85	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ann Seabright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Ida A. Whaley nurse
(Address) Southern Hospital

15 Filed JAN 15 1930 19 C. HAMPSON JONES, M. D. Registrar

Fee .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-14-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct- 1929 to Jan 13 1930,
that I last saw her alive on Jan. 13 1930,
and that death occurred, on the date stated above, at 8.10 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

one (duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? Clinical .....

(Signed) H C Kous ....., M. D.

1-14 1930 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 1/16 1930

20 UNDERTAKER William Cook

ADDRESS 247 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 53024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53024

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 136 N. Wolfe St., 6-9 Ward)

2-FULL NAME Michael Goller

(a) RESIDENCE NO. 130 N. Wolfe St., Ward

(Usual place of abode) 46 (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna Goller

6 DATE OF BIRTH (month, day, and year) July 20/1866

7 AGE	Years	Months	Days 22	IF LESS than 1 day hrs. or min.
	63	5	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pattern Filer 46
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Valve Co.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER Michael Goller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Anna Katz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Michael Golden (nephew)
(Address) 120 E. Birkhead
(Supplied by Wm Cook)

15 Filed 19 Registrar

N 15 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no -ka

What test confirmed diagnosis? Autopsy by Dr. Ruzic

(Signed) J. H. Haas M. D.

1/24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Burial	1/16/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53025

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53023

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 49-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Cook

(a) RESIDENCE NO. 116 S Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 12, 1887

7 AGE: Years 42 | Months 4 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wilhom H Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Wehrmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wilhom H Cook

(Address) 223 S Bunsel St

15 Filed , 19 C. HOMESON JONES, M. D. Registrar

JAN 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to Jan 15, 1930, that I last saw him alive on Jan 15, 1930, and that death occurred, on the date stated above, at 5 A.m.

The CAUSE OF DEATH* was as follows:

Heart disease; arteriosclerotic
Chronic nephritis
with edema

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel J. Helms, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 1/17 1930

20 UNDERTAKER: Wm Cook

ADDRESS 1217 E Baltimore St

Important. See instructions on back of certificates.

Spec.—1-13-23—M&T—500 Blks.

E 53026 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53026

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2226 W North ave ST. 8-16 WARD)

2-FULL NAME Carrie Bixby

(a) RESIDENCE NO. 2226 W. North Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Fayette Bixby

6 DATE OF BIRTH (month, day, and year) Jan 23 1865

7 AGE: Years 64 65 | Months 11 | Days 22 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at home
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Dauphin Pa

PARENTS

10 NAME OF FATHER Geo W. Cochlay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Catherine Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Miss Katharine D. Bixby
(Address) 2226 W. North ave

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 12 1930 to Jan 14 1930
that I last saw her alive on Jan 14 1930
and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia ca
Chronic Valvular heart disease
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? .....
Did an operation precede death? Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....

(Signed) Guston K. Baker, M. D.
1/15/1930 (Address) 3005 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 17 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53027

CERTIFICATE OF DEATH

E 53027

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 405 E. Lanvale St St. 17-14 Ward

2-FULL NAME Frank S. Chapman

(a) RESIDENCE NO. 405 E. Lanvale St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ella G. Chapman

6 DATE OF BIRTH (month, day, and year) Dec 8/1861

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	68	1	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cashier
(b) General nature of industry, business, or establishment in which employed (or employer) Stafford Hotel
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Talto., Md.

PARENTS

10 NAME OF FATHER Nichols Chapman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Talto., Md.

14 Informant Ella Chapman
(Address) 405 E. Lanvale St

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..., M. D.

1/15/30 (Address 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 1/17 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 W Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-00 E 53028

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 E 22nd St. WARD) 17-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harvey Carter Irwin

(a) RESIDENCE NO. 343 E. 22nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Irwin

6 DATE OF BIRTH (month, day, and year) May 31 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52 53	7		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John W. Irwin

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Emma V Carter

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs Mary E. Irwin

(Address) 343 E 22nd St

15 JAN 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 13, 1930, to January 15, 1930,

that I last saw h[illegible] alive on January 15, 1930

and that death occurred, on the date stated above, at 12.05 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

8 yrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By Symptoms

(Signed) Thomas J Hulse M. D.

, 19 (Address) 532 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Jan 16 1930
20 UNDERTAKER Wm. Cook	ADDRESS 1217 St Paul St

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53029

CERTIFICATE OF DEATH.

REGISTERED NO. 89 E 53029

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 53029

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 302 E North Ave ST. 12-14 WARD)

2-FULL NAME Geo W. Hardesty

(a) RESIDENCE NO. 302 E North Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Florence E Hardesty

6 DATE OF BIRTH (month, day, and year): Oct 2 1865

7 AGE: Years 64 | Months 3 | Days 13 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: George W Hardesty

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Myers

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto Co

14 Informant: Mrs Florence E Hardesty
(Address) 302 E north ave

15 Filed ..... 19..... Registrar

NOV 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 1930, to Jan 15 1930,

that I last saw him alive on Jan 15 1930

and that death occurred, on the date stated above, at 6.00 m

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary): none (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jeffries Buck, M. D.

11/15 1930 (Address) 5 Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Jan 17 1930

UNDERTAKER: H. S. Marshall

ADDRESS: 3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 53030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001 E 53030

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1250 Riverside Av ST. 24-33 WARD)

2-FULL NAME Elizabeth M. Tolson

(a) RESIDENCE NO. 1250 Riverside Av ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Tolson

6 DATE OF BIRTH (month, day, and year) April 12th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER George Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Miss Florence Tolson 1250 Riverside Av.

15 Filed JAN 16 1930 19 RPL Registrar

TION is very important See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 19 30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7 19 30 to Jan. 14 19 30

that I last saw her alive on Jan. 14 19 30

and that death occurred, on the date stated above, at 10 A. m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) C. H. Campbell M. D.

1/15 19 30 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Jan 17 1930

20 UNDERTAKER E Schloman & Son ADDRESS 1039 Hanover St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53031

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53031

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. _____ ST., 7-17 WARD)

2—FULL NAME Charles Kriss.

(a) RESIDENCE NO. 839 N. Patterson Pk Av ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beatrice Kriss

6 DATE OF BIRTH (month, day, and year) (unknown)

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 66 ✓

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Charles Kriss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Horby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Hospital Records
(Address)

15 Filed _____, 19 _____ Registrar

NOV 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/14/30

17 I HEREBY CERTIFY, That I attended deceased from 11-30, 19 30, to 11/14, 19 30

that I last saw h alive on 11/14, 19 30

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

? (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Partial intestinal obstruction

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Wm H. McFaul Jr, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 17 1930
20 UNDERTAKER Frank Graceffo	ADDRESS 1906 Eastern Av

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

E 53032

CERTIFICATE OF DEATH

E 53032

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto Gen Hosp ST. 725 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles R. Zamba

(a) RESIDENCE NO. 1430 Cherry St ST. Curtis Bay WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anastasia Zamba

6 DATE OF BIRTH (month, day, and year) Dec. 22 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55 yrs.	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Czecho-Slovakia

PARENTS

10 NAME OF FATHER Vincent Zamba

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Czecho Slovakia

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Anastasia Zamba

(Address) 1430 Cherry St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 '30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1930, to Jan. 15, 1930, that I last saw him alive on Jan. 15, 1930 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Ruptured Duodenal Ulcer

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Peritonitis & Cardiac Failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 1-10-30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) E. A. Estaing, M. D.

, 19 (Address) So Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Jan 18 19 30
20 UNDERTAKER Frank Brackbein	ADDRESS Roland

Important. See instructions on back of certificates.

NOV 6 1930

DEC 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53033

CERTIFICATE OF DEATH

90 ✓

E 53033

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2726 W. Baltimore ST. 90-69 WARD)

2—FULL NAME John E. Rush

(a) RESIDENCE NO. 2726 W. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L. Rush

6 DATE OF BIRTH (month, day, and year) June 18, 1880

7 AGE	Years	Months	Days 26	If LESS than 1 day, hrs. or min.
✓	49	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 025

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John M. Rush

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Margaret E. Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mr. Thomas Jefferson

(Address) 519 N. Linwood Avenue

15 Filed JAN 16 1930 HAYDEN JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/4 1928 to 1/14 1930

that I last saw him alive on 1/14 1930

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension Arterial Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure 260

(Signed) Chas A Rehn, M. D.

1/15 1930 (Address) 2105 W. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Jan. 17 1930

20 UNDERTAKER Joseph H Cook

ADDRESS 1003 West Baltimore St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 53034

E 53034

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4976 Edgemere Avenue ST. 27-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Steiner

(a) RESIDENCE NO. 4976 Edgemere Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Steiner

6 DATE OF BIRTH (month, day, and year) Jan. 20, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jesse DeHoff

11 BIRTHPLACE OF FATHER (city or town) Manchester

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sally Gettier

13 BIRTHPLACE OF MOTHER (city or town) Manchester

(State or country) Maryland

14 Informant Mr. Albert N. DeHoff

(Address) 4976 Edgemere Ave.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 13, 1930

that I last saw her alive on Jan 8, 1930

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. 2 mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. S. Tillett, M. D.

1-14, 1930 (Address) 2220 Garrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Jan. 16 1930

20 UNDERTAKER Arnold Cook

ADDRESS 1003 West Baltimore St.

JAN 16 1930 C. HAWTHORNE JONES, M. D.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53035

CERTIFICATE OF DEATH

E 53035

REGISTERED NO. 88

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Parren ST. 16-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Milligan

(a) RESIDENCE NO. 1007 Parren ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Milligan

6 DATE OF BIRTH (month, day, and year) June 20 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Cement Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Reisterstown Md

PARENTS

10 NAME OF FATHER Benj. Milligan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk.

12 MAIDEN NAME OF MOTHER N.K. Penn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Emma Milligan

(Address) 1007 Parren

15 JAN 16 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 14, 1930

that I last saw h alive on Jan 13, 1930

and that death occurred, on the date stated above, at 12:45 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Old age (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lenzes test

(Signed) Luther R. Fuhr M. D.

19 (Address) 1327 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery

DATE OF BURIAL Jan 18 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Eastman St

Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Johnson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53036 ✓

E 53036

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 540 Laurens ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Johnson

(a) RESIDENCE. NO. 540 Laurens ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter (C)

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer Little Balto. Md

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Bradley

(Address) 540 Laurens Street

15 Filed JAN 16 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 14, 1930.

that I last saw h[illegible] alive on Jan 14, 1930.

and that death occurred, on the date stated above, at 2.35 p. m.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia (Lobar)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis 17

Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Paul Scott, M. D.

, 19 (Address) 534 W. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan 16 1930
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53037

CERTIFICATE OF DEATH

90 ✓ E 53037

REGISTERED NO.

1—PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No. 1619 Aisquith ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Anna Fischer

(a) RESIDENCE NO. 1619 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 ~~COLOR OR RACE~~: White

5 Single, ~~Married, Widowed, or Divorced (write the word)~~: Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~: Single

6 DATE OF BIRTH (month, day, and year) Mar 26th 1858

7 AGE: Years 71 | Months 10 | Days 19 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): None . 064

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Gottlieb Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Heil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Margaret Fischer

(Address) 1506 N Eden St Balto Md

15 Filed JAN 16 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1929, to Jan. 15, 1930,

that I last saw h[illegible] alive on Jan. 15, 1930

and that death occurred, on the date stated above, at 10[illegible] Am.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel B Wolfe, M. D.

1/15/1930 (Address) 1331 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Jan. 11 1930

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 1126 E Monument St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53038 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53038

CERTIFICATE OF DEATH

REGISTERED NO. 27-48

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 202 Taplow Road ST., Homeland (WARD)

2—FULL NAME Augusta M. Hargest

(a) RESIDENCE NO. 202 Taplow Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Edward E. Hargest, Sr.

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	65	1	19	18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry R. Wustland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. E. E. Hargest, Jr.

(Address) 202 Taplow Road

15 Filed JAN 16 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1929, to Jan 14, 1930

that I last saw h[illegible] alive on Jan 13, 1930

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cardiovascular degeneration

Collapse & ruptured vessel

(cerebral)

CONTRIBUTORY (Secondary) Diabetes mellitus (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles A. Schamperd, M. D.

1/15, 1930 (Address) 2506 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL Jan 16 1929

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53039

CERTIFICATE OF DEATH.

186-103 E 53039

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) South Baltimore Gen. Hosp. (Street) Ward)

2-FULL NAME Emanuele Dantonio

(a) RESIDENCE NO. 1221 Battery Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Angela Dantonio

6 DATE OF BIRTH (month, day, and year) July 10 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	47	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Labor

(b) General nature of Industry, business, or establishment in which employed (or employer) Construction Yard

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Guy Dantonio

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Gatta

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Angela Dantonio

(Address) 1221 Battery Ave

Filed JAN 16 1930 HARRISON L. JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

18 CAUSE OF DEATH* was as follows: Fract Skull - Run into side of auto causing him to be thrown to street &c.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Pneumonia

(duration) yrs. mos. ds.

(Signed) D. J. Frame M. D.

(Coroner)

1/15 1930 (Address) 3939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Key Highway & Hebelle St

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Holy Redeemer Cem. Date of Burial Jan 17 1930

20 UNDERTAKER Jos. F. Denny ADDRESS 715 Light

Use typewriter if possible. Ans. to be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OF DEATH in plain terms, so that it may be

Spec.—1-10-21—M&T—1500 Bks.

E 53040

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53040

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 5239 St Charles Ave

CITY OF BALTIMORE: (No. " " ST., 7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Gohr.

(a) RESIDENCE NO. 5239 St Charles ST. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy T. Gohr

6 DATE OF BIRTH (month, day, and year): Oct 17 1868

7 AGE: Years 61 Months 2 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carman

(b) General nature of industry, business, or establishment in which employed (or employer): B&ORR

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ford Gohr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Arndt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Lucy T. Gohr (wife)

(Address) 5239 St. Charles Ave.

15 [illegible] HAROLD JONES, M. D.

Registrar

For

JAN 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1930, to Jan 14, 1930, that I last saw h[illegible] alive on Jan 14, 1930, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows: 1 Broncho-Pneumonia

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma

Many years (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy? No,

What test confirmed diagnosis?

(Signed) Otto B. Parker M. D.

19 (Address) 312 W Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old Salem Lutheran Church Cemetery Catonsville — DATE OF BURIAL: Jan 17 1930

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53041

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53041

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1004 Druid Park Drive (ST.) (WARD) 24-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. D. Akers

(a) RESIDENCE NO. 1004 Druid Park Drive ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 10 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George F. Akers

6 DATE OF BIRTH (month, day, and year) Mar 2 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Slatter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Matilda Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George F. Akers

(Address) 1004 Druid Park Drive

15 Filed JAN 16 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15 1929 to January 15 1930

that I last saw h[illegible] alive on January 15 1930

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency with Decompensation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Hanson Taylor, M. D.

Jan 16 1930 (Address) 211 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Jan 18 1930
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24-001

E 53042

CERTIFICATE OF DEATH

E 53942

1—PLACE OF DEATH Home for Incurables — REGISTERED NO. E-45

CITY OF BALTIMORE: (No. 40 ~~St~~ Rd + Cedar Ave. ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eleanor T. Brady

(a) RESIDENCE NO. 3402 Harford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Thomas F Brady Jr.

6 DATE OF BIRTH (month, day, and year) June 10, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William Patterson

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Howder

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Hospital Records
(Address)

15 Filed AUG 6 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1930, to Jan. 15, 1930, that I last saw her alive on Jan. 15, 1930, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Probable apoplexy

Five minutes (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ≠

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) H. S. Willis, M. D.

, 19 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Jan 18 1930

20 UNDERTAKER Wm. J. Tickner & Son — ADDRESS N. Pa. Ave.

Important. See instructions on back of certificates.

E 53043

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53043

CERTIFICATE OF DEATH.

REGISTERED NO. 53

1-PLACE OF DEATH

CITY OF BALTIMORE—NO. St. Joseph's Hospital ST. 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Emmit FORWOOD

(a) RESIDENCE NO. Stout, Maryland ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 8 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James W Forwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary R Sheridan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Herbert S Bailey Darlington Md.

15 Filed JAN 16 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-16 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-10- 1930 to 1-16 1930, that I last saw h/m alive on 1-16- 1930, and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Rt arm.

(duration) yrs. mos. 3 wks. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-11-30

Was there an autopsy? No Drainage

What test confirmed diagnosis? Clinical

(Signed) J McMenamin, M. D.

19 (Address) Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thomas Run Cem Harford Co Md — DATE OF BURIAL 1-19 1930

UNDERTAKER Herbert S Bailey — ADDRESS Darlington Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Maurice A Cole Jr.

HEALTH DEPARTMENT—CITY OF BALTIMORE

61-002

E 53044

CERTIFICATE OF DEATH

E 53044

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 8748

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maurice Albert Cole Jr.

(a) RESIDENCE NO. 3210 Ravenwood ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none.

6 DATE OF BIRTH (month, day, and year) Jan 15, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	9 hr

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Maurice Cole.

11 BIRTHPLACE OF FATHER (city or town) Balto Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Stock.

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Maurice Cole

(Address) 3240 Ravenwood ave

FEB 6 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 15, 1930, to January 15, 1930, that I last saw h[illegible] alive on January 15, 1930, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Accident of Labor;
Prolapse of umbilical Cord.
Asphyxia Neonatorum intra Uterum. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Version & breech extraction (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) James Graham Maudsley M. D.

1-16-1930 (Address) Memorial Auto Alley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lahwaty Cem DATE OF BURIAL June 14 1930.

20 UNDERTAKER Kendall & Chapel ADDRESS 300 N Columbus

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53045 47 E 53045

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5312 Catalpha Road ST., 27-44 WARD)

2—FULL NAME Mamie A. Bacon

(a) RESIDENCE NO. 5312 Catalpha Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Bacon

6 DATE OF BIRTH (month, day, and year) June 10, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	47	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Fred F.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

11 Informant Mildred R. Bacon

(Address) 5312 Catalpha Road

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

JUL 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1928 to Jan 15, 1930

that I last saw h alive on Jan 14, 1930

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) yrs. 18 mos. da.

CONTRIBUTORY (Secondary) Metastasis

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1928

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Wallace S. Thomas, M. D.

July 16, 1930 (Address) 1238 Mass Line

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy.	Jan 17 1930
20 UNDERTAKER	ADDRESS
John O. Mitchell & Son	1200 Eutaw Pl.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53046

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53046

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1422 Linden ave ST. 14-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James F. Johnson

(a) RESIDENCE NO. 1422 Linden ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Marion Griswold Feast

6 DATE OF BIRTH (month, day, and year) May 24 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Law & collections

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles R. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Charlotte M. Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. M. F. Johnson

(Address) 1422 Linden ave.

15 Filed JAN 16 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1930, to Jan 15, 1930, that I last saw him alive on July 15th 1930 and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas U. Larrick M. D.

Jan 16, 1930 (Address) 1327 Park Ave. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemy.

DATE OF BURIAL Jan 17 1930

20 UNDERTAKER John D. Mitchell & Sons

ADDRESS 1800 Eutaw Place

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53047

74-001

E 53047

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 204 W Monument ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Coles Carter

(a) RESIDENCE NO. 1204 W. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	80	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Robt. Hill Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. S.R. Carter

(Address) 204 W Monument St

15 Filed ANG 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-15-30

17 I HEREBY CERTIFY, That I attended deceased from —, 19 26, to 1-15, 19 30,

that I last saw her alive on 1-15, 19 30

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

(duration) 10+ yrs. mos. ds.

CONTRIBUTORY (Secondary) CEREBRAL HEMORRHAGE

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jos. F. Doney, M. D.

, 19 (Address) 1129 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 17 1930

20 UNDERTAKER	ADDRESS
Henry St. Jenkins Sons	McCulloh & Orchard Sts

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53048 — 90 — E 53048

CERTIFICATE OF DEATH

REGISTERED NO. 27-58

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4816 Palmer Avenue ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilbert J. Arenz

(a) RESIDENCE NO. 4816 Palmer Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Hofstetter

6 DATE OF BIRTH (month, day, and year) ---------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	42	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supervisor of Cafeteria

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Southern Hotel

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Arenz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. Kreamer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Anna M. Arenz

(Address) 4816 Palmer Avenue

15 JAN 16 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 15, 1930, that I last saw h alive on Jan 15, 1930 and that death occurred, on the date stated above, at 220 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Organic heart disease (duration) unknown

mitral incomp. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Phys. exam.

(Signed) Chas J. Keller, M. D.

1/16, 1930 (Address) 222 W. Monumental

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL 1/18 19 30

20 UNDERTAKER Henry U. Mears and Son

ADDRESS 805 N. Calvert

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

161-001

HEALTH DEPARTMENT—CITY OF BALTIMORE E 53049

E 53049

CERTIFICATE OF DEATH.

REGISTERED NO. 1352

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3500 Keswick Rd ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wisner

(a) RESIDENCE NO. 3500 Keswick Rd ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 16 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Herman E Wisner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Dreher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Herman Wisner

(Address) 3500 Keswick Rd.

15 C. HAMPSON JONES, M. D. Registrar

JAN 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1930

17 I HEREBY CERTIFY, That I attended deceased from — , 19 , to — , 19 ,

that I last saw h alive on — , 19 ,

and that death occurred, on the date stated above, at 3 hrs A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(6 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Isaac Druen, M. D.

Jan 16 1930 (Address) 846 Cathedral Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Consolidated Health

ADDRESS JAN 1 193

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—3-29-28—L. F. H.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53050

E 53050

CERTIFICATE OF DEATH

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Bucks. Ave ST. 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank P. Shelley

(a) RESIDENCE NO. 111 E. 24th St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie E. Shelley

6 DATE OF BIRTH (month, day, and year) Jan 23 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68 yrs.	11 mos.	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soda Clerk. 004

(b) General nature of industry, business, or establishment in which employed (or employer) Ice Cream & Confect

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER E. M. Shelley

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Rhoades

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Elsie Shelley

(Address) 111 E 24th St

15 Filed JAN 16 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15-30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10 1930 to Jan 15 1930

that I last saw h... alive on Jan 15 1930

and that death occurred, on the date stated above, at 12 15 m.

The CAUSE OF DEATH* was as follows:

Diabetes & Gangrene

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cardiac

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) E. E. Tolson, M. D.

1-15, 1930 (Address) 1213 Linden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Jan 17 1930

20 UNDERTAKER W. M. Coulton

ADDRESS 2238 W Balto

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53051

CERTIFICATE OF DEATH.

10 E 53051

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 720 Washington Blvd) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles. E. Meeks Jr

(Residence in Baltimore: No. 720 Washington Blvd St.; 18 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Dec (Month) 31 (Day), 1911 (Year)

7-AGE, 18 yrs. 1 mos. 15 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER, Charles. E. Meeks Sr

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Susan Woodley

13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E. Meeks Sr

(Address) 720 Washington Blvd

15- C. HAMPSON JONES, M. D.

Filed ....., 191..... Registrar.

JAN 16 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 15 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 10 1930. to Jan 15 1930. that I saw him alive on Jan 15 1930. and that death occurred, on the date stated above, at 4 00 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... yrs. ..... mos. 5 da.

CONTRIBUTORY (Secondary) Mitral insufficiency

(Duration) ? yrs. ..... mos. ..... da.

(Signed) Fred T. Lyter M. D.

Jan 16 1930 (Address) 5 N. Fremont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. London Park Cem

DATE OF BURIAL. Jan 18 1930

20-UNDERTAKER Jos Loeser & Son

ADDRESS 267 S. Pac

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53052

CERTIFICATE OF DEATH

160 E 53052

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 N. Collington Ave ST., 8-16 WARD)

2—FULL NAME Francis Edward Stalun

(a) RESIDENCE NO. 1931 N Collington ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	✓	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Robert Stalun

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Frances Canada

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Robert Stalun
(Address) 1931 N Collington Ave

15 C. HAMPSON JONES, M. D.
JAN 16 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1930, to Jan 15, 1930,
that I last saw h[illegible] alive on Jan 14, 1930
and that death occurred, on the date stated above, at 3 20 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Exposure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? a Primary case in Hospital 6 1/2 hrs

What test confirmed diagnosis?

(Signed) Edward J Cook, M. D.

1/15. 1930 (Address) 413 N Loudenwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 17th 1930

20 UNDERTAKER Leo S. Cook — ADDRESS 1783 N Patterson Park Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 53053 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53053

230595 Urol.

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Leggett

(a) RESIDENCE NO. Clarksburg W. Va ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of~~ Margaret

6 DATE OF BIRTH (month, day, and year) 5/12/56.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73.	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storage

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Ohio.

PARENTS

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Aileen Corkery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-16-30.

17 I HEREBY CERTIFY, That I attended deceased from 10-28, 1929, to 1-16-, 1930,

that I last saw him alive on 1-16-, 1930

and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bladder

Duration 2 years

~~(a) Last~~ yrs. mos. ds.

CONTRIBUTORY (Secondary) Bacteremia & Pyuria

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) George G. Turner, M. D.

Jan 16 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clarksburg W. Va	Jan 18 1930
20 UNDERTAKER Geo M. Smith & Son	ADDRESS 811 N Howard St.

important. See instructions on back of certificates.

JAN 16 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53054 | 101-001 | E 53054

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital | WARD 6-27 | (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marion Porter Gray

(a) RESIDENCE NO. 1504 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Gray

6 DATE OF BIRTH (month, day, and year) August 23, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Md —

PARENTS

10 NAME OF FATHER Timothy Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Liza Blade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry Gray (Address) 1504 W. Lanvale St.

15 Filed JAN 17 1930 C. HAWLEY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 14, 1930, that I last saw her alive on Jan 14, 1930 and that death occurred, on the date stated above, at 2.25 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos. 2 ds.

CONTRIBUTORY (Secondary) None —

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 1504 W. Lanvale St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings + X ray

(Signed) Addison Craft Irby, M. D.

19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL A.A. Co Calvary Cem. Arrived Md

DATE OF BURIAL Jan 17 1930

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Pennsdale

Spec.—1-12-23—M&T—500 Blks.

53055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 E 53055

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2105 Division St., 14-20 (WARD)

2-FULL NAME Marriott Lamont Burgess.

(a) RESIDENCE NO. 2105 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Newsdealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry J. Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Howell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Laura Burgess (Address) 2105 Division St

15 Filed JAN 7 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1929, to Jan. 14, 1930, that I last saw h[illegible] alive on Jan. 13, 1930, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis!

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. N. Pickett, M. D.

1/16, 1930 (Address) 1536 N. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louis Chapel — DATE OF BURIAL 1/18, 1930

20 UNDERTAKER Samuel Beasley — ADDRESS 1600 Mt St

SEE INSTRUCTIONS on back of certificates. This is very important

JAN 7 1930

Spec.—1-12-23—M&T—500 Blks.

E 53056

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 53056

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 Madison Ave St. 11-24 WARD)

2-FULL NAME Lucy A Scott

(a) RESIDENCE NO. 932 Madison ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Scott

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE 36 Years | Months | Days | If LESS than 1 day, hrs. or min.

36

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Betty Grandy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant (Address): Edward Scott 932 Madison

15 Filed ....., 19 ..... Registrar

JAMES H. JONES, M.D.

JAN 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/15 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/1 1930, to 1/15 1930,

that I last saw h alive on 1/15 1930,

and that death occurred, on the date stated above, at 9 45 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Clarke, M. D.

1/16 1930 (Address) 2129 Oak

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Lawn

DATE OF BURIAL 1/17 1930

20 UNDERTAKER: Samuel Kennedy

ADDRESS 1078

TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH

53057

REGISTERED NO. E 53057

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Harford Ave ST., 9-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Michel

(a) RESIDENCE NO. 1706 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if foreign birth? 78 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of the late

6 DATE OF BIRTH (month, day, and year) Jan. 14 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Koerner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss. Annie Fuss (Address) 5203 Craig Av. Swissvale

15 Filed G. H[illegible] Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 16 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1927, to Jan 16, 1930, that I last saw h[illegible] alive on Jan 14, 1930 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

{Cerebral Apoplexy
{Hemorrhage 3

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John Patrick, M. D.

Jan. 19 30 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Sat Jan. 18 1930

20 UNDERTAKER Henry Hoecker Sons Inc.

ADDRESS 1401 E. Oliver St

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53058 ✓ 002

E 53058 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3103 Orlando Ave ST. 19-25 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Otilia Frank

(a) RESIDENCE NO. 402 S. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of Samuel W. Frank

6 DATE OF BIRTH (month, day, and year) Jan. 26, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Herman Kriening

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Emma Hetzel daughter

(Address) 3103 Orlando ave

15 Filed ..... 19 ..... RLM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/16 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1929 to 1/16 1930,

that I last saw h[illegible] alive on 11/5 1930,

and that death occurred, on the date stated above, at 8:17 A. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver

(duration) 1 yrs. 6 mos [illegible] ds.

CONTRIBUTORY (Secondary) Toxemia (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. A. Sigrist, M. D.

1/16, 1930 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan. 18, 1930

20 UNDERTAKER Harry N. Twitchell, 410 Edmondson Ave. ADDRESS

TION is very important See instructions on back of certificates.

Spec.—7-13-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53059

CERTIFICATE OF DEATH

100-001

X 100 E 53059

REGISTERED NO.

1-PLACE OF DEATH Maryland General Hosp.

City of BALTIMORE: (No. ____ St., 1 Ward) 1-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Ray

(a) RESIDENCE NO. West Friendship, Md. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. 17 ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/10/1870

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	51	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) Carroll Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Ray

11 BIRTHPLACE OF FATHER (City or town) ____

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Fischer

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Germany

14 Informant Hospital Record.

(Address)

15 Filed ____ 19 ____ Registrar

M.N.T. ____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/17/ 19 30

17 I HEREBY CERTIFY, That I attended deceased from 1/14, 19 30, to 1/17, 19 30

that I last saw him alive on 1/17, 19 30

and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Robert Wells, M. D.

, 19 (Address) Md. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. View Cem. Date of Burial Jan 20 19 30

20 UNDERTAKER Eastes Sons ADDRESS Ellicott City

JAN 17 1930 C. HAGERSTOWN, MD.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53060

CERTIFICATE OF DEATH

100 E 53060

REGISTERED NO. 1-24

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert McMillan

(a) RESIDENCE NO. 1319 Madison Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. ? 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	3 ?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of indastry, basiness, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Evelyn McMillan

13 BIRTHPLACE OF MOTHER (city or town) U. S.
(State or country)

14 Informant Record of St. Lukes Home
(Address) 1319 Madison Ave

15 Filed , 19 Rldt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-16-30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1930, to Jan 16, 1930

that I last saw h... alive on Jan 16, 1930

and that death occurred, on the date stated above, at 1 30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Primary)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Carroll M. St Clair M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 1/17/1930

20 UNDERTAKER Mrs. Geo. E. Holland

ADDRESS 1631 Druid Hill Ave

Important. See instructions on back of certificates.

LAST VISIT

Spec.—8-16-29—L. F. S.—10) Eks.

E 53061 E 53061

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 Linnard ST., 16-6T WARD)

2—FULL NAME Thomas Green,

(a) RESIDENCE NO. 715 Linnard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E.Green,

6 DATE OF BIRTH (month, day, and year) July 19.1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 047

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Green,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Huber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant R.B. LeFevre (Address) 715 Linnard St.

15 Filed JAN 17 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 15 1930

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw h[illegible] alive on [illegible] 14, 19[illegible], and that death occurred, on the date stated above, at 6 [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1/17, 1930 (Address) 1014 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

20 UNDERTAKER Geo W. Little

DATE OF BURIAL JAN 17, 1930

ADDRESS 2700 EDMONDSON AVE.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53062

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-001 E 53062

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Matthew Federhoff

(a) RESIDENCE NO. 513 Eastern Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) no? 1884

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? 040

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) Poland

PARENTS

10 NAME OF FATHER Theodore Federhoff

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Poland

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed JAN 17 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-15-30

17 I HEREBY CERTIFY, That I attended deceased from 1-7, 1930, to 1-15, 1930, that I last saw him alive on 1-15, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis, (R)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic, & aneurysm of aorta (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical: X-ray

(Signed) Marion M. McLean, M. D.

1-16, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russia Independent	Jan. 17, 1930
20 UNDERTAKER	ADDRESS
John Grebliauskas	423 S. Paca St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53063

CERTIFICATE OF DEATH

154

REGISTERED NO. E 53063

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH Baltimore City Hosp

CITY OF BALTIMORE: (No. ~~Eliza Dyer~~) ST., 22-31 WARD)

2—FULL NAME Eliza Dixon Spriggs

(a) RESIDENCE NO. 212 Hamilton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 21

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Spriggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lizzie Hayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed 1-17-30 [illegible] M. D.
Registrar

N 71338

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-13-30

17 I HEREBY CERTIFY, That I attended deceased from 12-11, 1929, to 1-13, 1930,

that I last saw her alive on 1-13, 1930

and that death occurred, on the date stated above, at 5-25 A. m.

The CAUSE OF DEATH* was as follows:

Carc. ulceration of both legs.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. W. Longshore, M. D.

1-13, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 1/17 1930

20 UNDERTAKER Geo. T. A. Gibson

ADDRESS 1353 Edmondson Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53064

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

148 E 53064

1—PLACE OF DEATH Franklin Square Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 27-16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Margaret Chenoweth

(a) RESIDENCE NO. 4755 Park Heights ave ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Norman Chenoweth

6 DATE OF BIRTH (month, day, and year) Oct 8 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0-24

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER John Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Martha Bollitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Norman Chenoweth

(Address) 4755 Park Heights Ave

15 Filed JAN 17 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930, to Jan 15, 1930, that I last saw her alive on Jan 15 1930 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Post Partem Eclampsia

over

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) M B Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Jan 18 1930

20 UNDERTAKER Chenoweth Son

ADDRESS 2411 Eutaw

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53065

CERTIFICATE OF DEATH

101-001

E 53065

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 2-4 Ward)

2-FULL NAME Thomas McNulty

(a) RESIDENCE NO. 518 S Register St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary McNulty

6 DATE OF BIRTH (month, day, and year) aug. 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	about 40	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Sparrow's Pt., Md

PARENTS

10 NAME OF FATHER Patrick ~~Thomas~~ McNulty

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Casey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Lilly & Zeiler Inc.
(Address) 403 S. Wolfe St

15 Filed JAN 7 1930 16 [illegible] JONES M. D. Registrar
By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia
Empyema
Endocarditis
(duration) yrs. mos. 045 ds.

CONTRIBUTORY (Secondary) Alcoholism
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins

What test confirmed diagnosis?

(Signed) [signature] M. D.

1/16/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Ecroll Cem.	Jan 17 1930
20 UNDERTAKER Lilly & Zeiler Inc.	ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53066

E 53066

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 31 E Aisquith St., 2nd Ward)

2-FULL NAME Mary Petza

(a) RESIDENCE NO. 31 E Aisquith St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Petza

6 DATE OF BIRTH (month, day, and year) Nov 11 - 1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	55	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER John Esther

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant
(Address)

15 Filed, 19 Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

a Hypostasis
Errors of Diet

(duration) yrs. mos. 1 wk. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No Hx & Autopsy

What test confirmed diagnosis? —

(Signed) M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Jan 16 1930
20 UNDERTAKER	ADDRESS
Lilly & Zeiler inc	403 S. Wolfe

APR 7 1938 [illegible] M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53067

CERTIFICATE OF DEATH

100-001

E 53067

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 849 W. Franklin ST. 16-26 WARD)

2—FULL NAME Susan Sutton

(a) RESIDENCE NO. 849 W Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 46 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mason Tolivier

(Address) 849 W Franklin St

15 Filed JAN 17 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930 to Jan 16, 1930

that I last saw h alive on Jan 16, 1930

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

19 (Address) 1513 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 1-17 1930

20 UNDERTAKER: David Eaton

ADDRESS 816 Pa Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53068 — 1-PLACE OF DEATH

44

E 53068 — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. West Balto General Hosp ST., 7th WARD)

2-FULL NAME Wayman Herring

(a) RESIDENCE NO. 113 × Etting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Ca

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Olivia Price

(Address) 113 Etting St

15 Filed JAN 7 1930, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1930, to Jan 16, 1930,

that I last saw h alive on Jan. 16, 1930

and that death occurred, on the date stated above, at 1:45 P. m

The CAUSE OF DEATH* was as follows:

Papillomatous carcinoma of bladder

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/6/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) S. A. Hess, M. D.

, 19 (Address) West Balto Genl Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	1-17 1930
20 UNDERTAKER David Easton	ADDRESS Pac Ave

JAN 7 1930

TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53069

HEALTH DEPARTMENT—CITY OF BALTIMORE

94-08 E 53069

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2407 E Hoffman St., 6-16 WARD)

2—FULL NAME Conrad Fries

(a) RESIDENCE NO. 2407 E Hoffman St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Fries

6 DATE OF BIRTH (month, day, and year) July 14 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Augusta Fries

(Address) 2407 E Hoffman

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 13th, 1930, to Jan 15th, 1930, that I last saw h in alive on Jan 15th 1930 and that death occurred, on the date stated above, at 6 15 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Arthur C Monnoyer, M. D.

1-16, 1930 (Address) 800 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Jan 18, 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Allens

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53070 49 E 53070

E 53070

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 724 WARD)

2—FULL NAME Ernest Goth

(a) RESIDENCE NO. 2302 E. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —— ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61 ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer) ? 014

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) Germany

PARENTS

10 NAME OF FATHER Anton Goth ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Goth

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed —— 19—. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-14-30

17 I HEREBY CERTIFY, That I attended deceased from 1-7, 1930, to 1-14, 1930, that I last saw him alive on 1-14, 1930 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate ?

(duration) over yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Peripheral Neuritis (duration) 1 yrs. 12 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Hist: P.C.: X-ray: Path. Findings

(Signed) Marion M. McLean, M. D.

1-15, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Jan 18, 1930

20 UNDERTAKER John Allrich ADDRESS 2008 Aliceanna

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 53071

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6517 Fair Ave ST., No 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Wheeler

(a) RESIDENCE NO. 6517 Fair Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Edwin C Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ora E. Grossman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edwin C Wheeler

(Address) 6517 Fair Ave

15 Filed JAN 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/13, 1930, to 1/15, 1930, that I last saw h[illegible] alive on 1/15 1930 and that death occurred, on the date stated above, at 1 45 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Primary

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) G. G. Thomasteen, M. D.

1/16/30 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Jan 18 1930

20 UNDERTAKER John Wenck

ADDRESS 2008 Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

E 53072 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 53072

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 n Luis ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm Isaac Henderson

(a) RESIDENCE NO. 313 n Luis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Dyer

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0+0

(c) Name of employer 3+0

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John A Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Skinner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Henderson

(Address) 1508 E Monument St

15 Filed JAN 17 1930, 19 Flt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-16-30

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 16, 1930, that I last saw h[illegible] alive on Jan 16, 1930 and that death occurred, on the date stated above, at 330 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Sonya S Able, M. D.

-17. 1930 (Address) 508 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cyprus

DATE OF BURIAL Jan 18 1930

20 UNDERTAKER John W Henderson

ADDRESS 1502 E Monument

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53073

CERTIFICATE OF DEATH.

109 E 53073

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument St (ST.) 15-6th (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Sessler

(a) RESIDENCE NO. 2825 W. Garrison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
22		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Draftsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Rochester N Y

PARENTS

10 NAME OF FATHER: Otto Sessler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Ethel Logan

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Pennsylvania

14 Informant (Address): Otto Sessler, 2825 W. Garrison Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 16, 1930, that I last saw him alive on January 16, 1930, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Bronchopneumonia - both lungs

(duration) 2 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Severe Vincents infection of tonsils and pharynx

(duration) 0 yrs. 0 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & laboratory findings

(Signed) [illegible] M. D.

1/16, 1930 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bals Hebrew Cem

DATE OF BURIAL: 1/17 1930

20 UNDERTAKER: Jack Lewis 1534 E Balto

ADDRESS

CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 17 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53074

CERTIFICATE OF DEATH

E 53074

REGISTERED NO. 426-41

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4143 Kiernan Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabella Williams

(a) RESIDENCE NO. 4143 Kiernan Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. H. Williams

6 DATE OF BIRTH (month, day, and year): Jan 11 1860

7 AGE: Years 69 | Months 9 | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Livingston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Geo H. Williams

(Address): 4143 Kiernan Ave

15 Filed: NOV 7 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 16, 1930, that I last saw h alive on 19, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Brights Disease

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

Influenza, (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustave Fritz, M. D.

1/16, 1930 (Address) Overlea

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem

DATE OF BURIAL: Jan 18 1930

20 UNDERTAKER: Philip Herwig

ADDRESS: 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53075

CERTIFICATE OF DEATH

129 E 53075

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Windemere ave ST., 47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Reisenweber

(a) RESIDENCE NO. 1715 Windemere ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: Beatrice A Reisenweber

6 DATE OF BIRTH (month, day, and year): Aug 23 60

7 AGE: Years 69 | Months 4 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer: himself

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John Reisenweber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Del.

12 MAIDEN NAME OF MOTHER: Elizabeth Lechner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del

14 Informant: Beatrice A. Reisenweber

(Address): 1715 Windemere ave

15 Filed JAN 17 1930 19 RLH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 9 1930 to Jan 15 1930

that I last saw h alive on Jan 15 19

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart

Duration yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis

Chronic Nephritis (Duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C H Meyer Jr M. D.

1930 (Address) 1533 E. 33rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine

DATE OF BURIAL: Jan 18 1930

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Aliceanna St

Spec.—2-29-28—L. F. S.—500 Bks.

E 53076

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 53076

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 4909 Falls Road ST. 27-53 WARD)

2—FULL NAME Sara Frances Norton

(a) RESIDENCE NO. 4909 Falls Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 3 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Norton

6 DATE OF BIRTH (month, day, and year): Oct. 9, 1856

7 AGE: Years 73 | Months 3 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Dr. Perry S. Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Mr. Frank Norton

(Address) 4909 Falls Rd.

15 Filed JAN 7 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to January 15, 1930, that I last saw h or alive on January 15, 1930, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. 15 ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Henry D Stahr, M. D.

1/16 1930 (Address) 411 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Jan. 18 1930

20 UNDERTAKER: Wm Pickner Sons

ADDRESS: North & Pa

Spec.—7-17-26—A Co.—200 Bks.

53077

HEALTH DEPARTMENT—CITY OF BALTIMORE E 53077

CERTIFICATE OF DEATH

REGISTERED NO. 132

1-PLACE OF DEATH Maryland General Hospital

City of BALTIMORE: (No. 20 St., W. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton White

(a) RESIDENCE NO. M.E. Home for the Aged Fulton & Franklin Sts St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Ida B. White

6 DATE OF BIRTH (month, day, and year) July 10, 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	75	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Montgomery Co. Md.

PARENTS

10 NAME OF FATHER Benjamin White

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Montgomery Co. Md.

12 MAIDEN NAME OF MOTHER Ellen Nicholson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Montgomery Co. Md.

14 Informant (Address) Hospital Records

15 Filed JAN 7 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1930 Jan. 15

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4 1930 to Jan. 15 1930

that I last saw him alive on Jan. 15 1930

and that death occurred, on the date stated above, at 9:45 p m.

The CAUSE OF DEATH* was as follows:

Uremia, Sudden Stone

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of 1/8/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Thompson Hoge M. D.

1/15/30 (Address)

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. Date of Burial Jan 18 1930

20 UNDERTAKER Wm J Tuckner Sons ADDRESS Mord & Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53078 | 185 E 53078

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 53078

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 7-4 Ward)

2-FULL NAME Carl Wolf

(a) RESIDENCE NO. 700 S. Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) June 15 - 1909

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	20	7	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Union Shipbuilding Co

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Wolf

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Geothey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. John Wolf (Father)
(Address) 700 S. Wolfe St

15 Filed JAN 19 1930 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture + dislocation of 12th thoracic vertebra + laceration of spinal cord.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) none

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Union Shipbuilding Co

Did an operation precede death? Yes Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Feller M. D.

1/16 1930 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery.	Jan. 20 1930
20 UNDERTAKER Henry Sander & Sons, Inc.	ADDRESS Baltimore St & Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53079

CERTIFICATE OF DEATH

161-00

E 53079

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST. 8-17 WARD)

2—FULL NAME Baby Wickins

(a) RESIDENCE NO. 132 N. Dallas ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced. (write the word) Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 10, 1930

7 AGE Years Months Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Wickins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Carrie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant L. Douglas

(Address) Johns Hopkins Hospital

15 Filed JAN 7 1930 H. M. CAMPBELL, M. D. Registrar.

1268

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-10, 1930 to 1-13, 1930 that I last saw h[illegible] alive on 1-13, 1930 and that death occurred, on the date stated above, at 12.45 A m.

The CAUSE OF DEATH* was as follows:

Extra Cranial Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

there an autopsy? Yes

What test confirmed diagnosis? L. Douglas, M. D.

(Signed) L. Douglas, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JAN 7 1930

Spec.—1-12-23—M&T—500 Blks.

E 53080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

73

E 53080

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 Cecil av ST., 9-46 WARD)

2-FULL NAME Frank. a. Claus.

(a) RESIDENCE NO. 2202 Cecil av ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary. Broyn.

6 DATE OF BIRTH (month, day, and year) April 2 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
42		8 9	13 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broom Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

045

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Fredrick. C. Claus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine. Mauling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Marie C. Haskel
(Address) 2202. Cecil av.

15 Filed JAN 17 1930. 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15- 1930.

17 I HEREBY CERTIFY, That I attended deceased from Apl. 1929. to Jan. 15- 1930.

that I last saw him alive on Jan. 15- 1930.

and that death occurred, on the date stated above, at 5th P. m.

The CAUSE OF DEATH* was as follows:

Spinal Paralysis (Chronic Myelitis)

(duration) 11 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ... Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. L. Hawkins M. D.

1/14/1930 19 (Address) 1216 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer Cemetery

DATE OF BURIAL Jan. 18 1930

20 UNDERTAKER Geo. - f Ruth

ADDRESS 1735 Harford av

See instructions on back of certificates.

TION is very important

Spec.—2-29-28—L. F. S.—500 Bks.

E 53081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 53081

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1929 Annapolis Av (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A Milus

(a) RESIDENCE NO. 1929 Annapolis Av ST. WARD
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Milus

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hardwood Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Milus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Adline Julubees

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Barbara Milus (Address) 1929 Annapolis Av

15 Filed 1/19 19 29 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 19 30 to Jan 13 19 30, that I last saw him alive on Jan 13 19 30 and that death occurred, on the date stated above, at 4:40 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Not Known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis + Shock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Carl P Rostling, M. D.

, 19 (Address) 18 W. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 1/18 1929

20 UNDERTAKER Edward Loudon

ADDRESS 235 Park Ave

IMPORTANT: For instructions see back of certificate.

R1 7 1930

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53082

E 53082

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 27 30 WARD

2-FULL NAME Samuel D. Epstein

(a) RESIDENCE NO. 610 S. Kenwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years 68 Months Days

If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED Retired

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nocah Epstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Frieda -

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Rachel Epstein 610 S. Kenwood Ave

Filed JAN 17 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Jan 16, 1930,

that I last saw h alive on Jan 16, 1930,

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. A. Cohen M. D.

1/16, 1930 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Natmar Westminster Rd DATE OF BURIAL 1/17, 1930

20 UNDERTAKER Lee Levenson & Bro ADDRESS 1127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53083 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53083

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

2—FULL NAME William Holland

(a) RESIDENCE NO. Chester Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Black | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie Holland

6 DATE OF BIRTH (month, day, and year): 1885

7 AGE: Years 45 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): 010
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS
10 NAME OF FATHER: Ross Holland
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Margt Allen
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 F... C. H. ... M. D.
... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan-16-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Jan 16, 1930, that I last saw him alive on Jan 16, 1930 and that death occurred, on the date stated above, at 11 56 A m.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction

(duration) yrs. mos. 6 ds.
CONTRIBUTORY (Secondary) Localized Peritonitis
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home 12/25/29 (1)
Did an operation precede death? Yes Date of 1/12/30 (2)
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Randolph Jones Jr M. D.
19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chester Pa. | DATE OF BURIAL: Jan 17 1930

20 UNDERTAKER: Samuel T Wensley | ADDRESS 578 N Bond

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

B 53084

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 53084

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5801 Kavon ave ST. 25-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Wieland

(a) RESIDENCE No. 5801 Kavon Ave., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, ~~Married, Widowed, or Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept. 14-1874

7 AGE — Years: 55 — Months: 4 — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tobacco Stripper

(b) General nature of industry, business, or establishment in which employed (or employer): Oth

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm Wieland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Stork

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm Wieland Jr. (Address): 5801 Kavon ave

15 Filed JAN 17 1930 19 RMH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/16 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/1, 1930, to 1/16/30, 19..., that I last saw h[illegible] alive on 1/16, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustave A Wolf, M. D.

1/16, 1930 (Address) Overlea.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Jan. 19 1930

20 UNDERTAKER: George W Zinkler — ADDRESS: 1737 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-28—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53085

101-001

CERTIFICATE OF DEATH.

E 53085

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 St. Stephens Street S. 16-67 WARD)

2-FULL NAME Isabella L. Harne

(a) RESIDENCE NO. 1615 St. Stephens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 11 yrs. 1 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov-30-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Garfield (State or country) Maryland

PARENTS

10 NAME OF FATHER William Glenn Harne

11 BIRTHPLACE OF FATHER (city or town) Garfield (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edna May Pryor

13 BIRTHPLACE OF MOTHER (city or town) Garfield (State or country) Maryland

14 Informant Dr. O. L. Harne (uncle)

(Address) 3210 Wolbrook Avenue.

15 Filed. ..... 19 ..... Registrar

APR 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Jan 15, 1930, that I last saw her alive on Jan 15, 1930 and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Respiratory Failure

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Carl P Roetling, M. D.

, 19 (Address) 1822 W. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Garfield, Frdk. Co. Md. DATE OF BURIAL Jan 18 1930.

20 UNDERTAKER Stewart & Mowen Co. ADDRESS 108-10 North Ave

TION is very important See instructions on back of certificates.

Cor.—16-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53086

CERTIFICATE OF DEATH

86 E 53086

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 756 W. Saratoga St. 4-26 Ward)

2-FULL NAME Howard Melvin Kelley

(a) RESIDENCE NO. Prince George's County near Laurel. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Kelley

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer 086
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. Kelley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth DeZarker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Mrs. M. F. Keyser
(Address) Baltsville, Md.

15 1-17-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Kelley, M. D.

1/17. 1930. (Address) 2309 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ivory Hill cemetery	Jan 20 1930
20 UNDERTAKER E. F. Fisher	ADDRESS Laurel Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53087

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53087

CERTIFICATE OF DEATH

91-007

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 3735 Roland Ave ST., 13-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura E. Laird

(a) RESIDENCE NO. 3735 Roland Ave ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 3 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Laird

6 DATE OF BIRTH (month, day, and year) Oct. 14-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	3	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John M. Vandegrift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Fielding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Carrie F. Laird

(Address) 3735 Roland Ave

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

JAN 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16-1930.

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to Jan 16, 1930, that I last saw her alive on Jan. 15, 1930 and that death occurred, on the date stated above, at 8 55 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral and general arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystectomy

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Arteriosclerosis

(Signed) Howard A, M. D.

Jan 7, 1930 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jan. 18-1930.

20 UNDERTAKER Horace F. Burgee — ADDRESS 3631 Falls Road

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53088 E 53088

CERTIFICATE OF DEATH

149

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 Division ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Shepherd

(a) RESIDENCE NO. 1647 Division ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Married

5a If married, widowed, or divorced, (or) WIFE of Stephen H Shepherd

6 DATE OF BIRTH (month, day, and year) June 4-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Md

PARENTS

10 NAME OF FATHER Barton Short

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Mellone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Stephen Shepherd

(Address) 1647 Division St

15 Filed 1-17, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 15-1930

17 I HEREBY CERTIFY, That I attended deceased from November 4, 1929, to January 15 1930, that I last saw her alive on January 13, 1930 and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Recurrent Tumor in Left Inguinal region

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pyelo Nephritis and Cancer (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? at hospital death

Did an operation precede death? Yes Date of Dec 5-1929

Was there an autopsy? No

What test confirmed diagnosis? Tests at Hospital & Clinic

(Signed) J Bonnell Lango M. D.

1-15, 1930 (Address) 2937 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 1/18/30

ADDRESS

20 UNDERTAKER Geo. C. Weber & Son 140 Mosher

Important. See instructions on back of certificate.

1-7-1930

Spec.—1-10-21—M&T—1500 Blks.

E 53089

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53089

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 25-72 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Louisa Floyd

(a) RESIDENCE NO. 28 Melrose Ave St. Catonsville Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Floyd.

6 DATE OF BIRTH (month, day, and year): [illegible] 1864

7 AGE: Years 65 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): 0 37

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Melvin

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Whitaugh.

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Maryland

14 Informant (Address): Hosp Records

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Jan. 17 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-15 1930 to 1-17 1930

that I last saw her alive on 1-17 1930

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Generalized arterio sclerosis

Chronic nephritis Cerebral Hemorrhage

Diabetes mellitus

(duration) yrs. mos 27 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

1930 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cemetery DATE OF BURIAL Jan. 21 1930

20 UNDERTAKER: Easton Sons ADDRESS Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53090

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53090

CERTIFICATE OF DEATH

REGISTERED NO. 91-102

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 N. Montford ave ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances E. North

(a) RESIDENCE NO. 27 N. Montford ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Capt. Ruf. North

6 DATE OF BIRTH (month, day, and year) Oct. 14 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	91	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (ar employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Barrott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Kate E. McClean

(Address) 27 N. Montford ave.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

1 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1930 to Jan. 17, 1930

that I last saw h.. alive on Jan. 16, 1930

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Emerson M. D.

1. 17. 1934 (Address) 519 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL Jan. 20 1930

20 UNDERTAKER Wm. C. Black ADDRESS 927 N. Broadway

Spec.—8-16-29—L. F. S.—100 Blks.

Dr Atchinson, 4012 Park Heights Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53091 — CERTIFICATE OF DEATH — 29 E 53091

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2920 Boarman Ave ST. 15-58 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Ransone

(a) RESIDENCE NO. 2920 Boarman Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Ransone

6 DATE OF BIRTH (month, day, and year): Oct 24, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): 62

(c) Name of employer: B&ORR

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: James Ransone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ann Whittlefield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Emma Ransone

(Address) 2920 Boarman Ave

15 Filed: C. HAMPSON JONES, M. D. 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1. 1929. to Jan 15. 1930.

that I last saw him alive on Jan 15. 1930

and that death occurred, on the date stated above, at 5-45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatic Nephritis

Cardiac insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James J. Atchinson, M. D.

1-16. 1930 (Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery — DATE OF BURIAL: Jan 6. 1930

20 UNDERTAKER: Wm. Cook — ADDRESS: 1517 St Paul St

Important: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53092

CERTIFICATE OF DEATH

167-E 53092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 805 N. Gilmor St., 16-27 Ward)

2-FULL NAME Norman Jones

(a) RESIDENCE NO. 805 N. Gilmor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Nov 28-1842

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	87	1	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boot Black
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Alex Jones

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jenny Smith

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary Jones
(Address) 1346 Woodyear

17 Filed Jan 18 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan 14th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, aut
(Inquest, autopsy or inquiry) find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH was as follows: Suicide by Cut throat in
Asphyxia (duration) yrs. mos. da. Suddan

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No Was Surgeon

What test confirmed diagnosis? Eyewitness

(Signed) H. Black, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Jan 18 1930
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1823 Preston ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53093

CERTIFICATE OF DEATH

3 1 ✓ E 53093

1—PLACE OF DEATH

REGISTERED NO. 27-56

CITY OF BALTIMORE: (No. 5033 Belmont Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Dawson Dashiell

(a) RESIDENCE NO. 5033 Belmont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

(a) If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Hampden T. Dashiell

6 DATE OF BIRTH (month, day, and year) March 27-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Wellington L. Dawson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia L. Simpson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Wellington L. Dawson (Address) 2742 Alameda Ave

15 Filed JAN 17 1930, 19 ... Registrar

HAMPSON JONES, JR.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15th, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1928, to Jan 15th, 1930, that I last saw her alive on Jan 14th, 1930 and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) L. L. Eordy, M. D.

1-16, 1930 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Jan. 18 1930

20 UNDERTAKER Hughes & Goad Inc — ADDRESS 417 W Broadway

Spot.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53094

CERTIFICATE OF DEATH.

74 01 E 53094

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 Sedney ave ST. 25-32 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Pettes

(a) RESIDENCE NO. 2201 Sedney ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida V. Pettes

6 DATE OF BIRTH (month, day, and year) 1863 June 17

7 AGE	Years	Months	Days	If LESS than 1 day.. hrs. or.... min.
	66	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman Gas Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Gilbert Pettes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Pettes

(Address) 2201 Cedar ave

15 Filed C. HAMPSON JONES, M. D. Registrar

JAN 17 1930 By

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 16, 1930, that I last saw h[illegible] alive on Jan 16, 1930, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) no yrs. no mos 3 ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) no yrs. no mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? paralysis of Hy sucle

(Signed) Raymond Callahan, M. D.

Jan 16, 1930 (Address) 2705 Hollins Ferry Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross G. A. Cs	Jan. 18, 1930
20 UNDERTAKER	ADDRESS
Margaret S. Flynn	1477 Eight St

Spec. 8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

232939 E 53095 — 129 E 53095

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. ____ ST. 1-3 WARD)

2—FULL NAME John Swiander

(a) RESIDENCE NO. 2226 Fleet ST., ____ WARD F
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) June 20 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	36	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steadier

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Swiander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

Filed JAN 16 1930 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930 to Jan 15, 1930, that I last saw him alive on Jan 15, 1930 and that death occurred, on the date stated above, at 8 03 a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Uremia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? Yes

What test confirmed diagnosis? Blood chemistry

(Signed) Hedwig Kaercey, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem — DATE OF BURIAL Jan 18 1930

20 UNDERTAKER John M Weber 401 — ADDRESS Chester St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53096 HEALTH DEPARTMENT—CITY OF BALTIMORE √E 53096

CERTIFICATE OF DEATH × 31

1—PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 4-30 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Thomas Dunford.

(a) RESIDENCE NO. 6766 Woodley Rd. Dundalk WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Dunford

6 DATE OF BIRTH (month, day, and year) March 27 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	9	20 30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Johnstown Pa

PARENTS

10 NAME OF FATHER John Dunford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Johnstown Pa

12 MAIDEN NAME OF MOTHER Abie Browley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Irwin Pa

14 Informant John Dunford
(Address) Johnstown Pa.

15 C. THAMPSON JONES, M. D.
JAN 18 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-17-1930

17 I HEREBY CERTIFY, That I attended deceased from December 28, 1929, to January 17, 1930, that I last saw h.. alive on January 17 —, 1930 and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic bilateral pulmonary Tuberculosis.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia - Lobar,

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-2-1930.

Was there an autopsy? Yes.

What test confirmed diagnosis? Physical signs + autopsy findings

(Signed) C. W. Peake M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnstown Pa. DATE OF BURIAL Jan 18 1930

20 UNDERTAKER John C. Miller ADDRESS 435 E Oliver

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53097

CERTIFICATE OF DEATH

1001 E 53097

REGISTERED NO. 167

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1339 N. Fulton St. 15-27 Ward)

2-FULL NAME Wm F. Markert.

(a) RESIDENCE NO. 1339 N. Fulton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie R. W. Markert

6 DATE OF BIRTH (month, day, and year) Mar 17-1864 ~~Mar 15-1864~~

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	65 ~~66~~	9	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chemist
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Chas. Markert
11 BIRTHPLACE OF FATHER (city or town) ~~Germany~~
(State or country) France
12 MAIDEN NAME OF MOTHER Wiedmann
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Carrie Markert
(Address) 1339 N. Fulton

15 Filed JAN 18 1930 G. HAMPSON JONES, M. D. Registrar
By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ~~his~~ death by ... (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide (Strangulation)

Asphyxia (duration) ... yrs. Sudden

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.

Jan 15 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 18 1930
20 UNDERTAKER Wm J Tuckner & Sons	ADDRESS N & Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 18 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 53098 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53098

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto. Gen. Hosp. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence E. Galloway

(a) RESIDENCE NO. Birch Ave Halethorpe Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4. COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Galloway

6 DATE OF BIRTH (month, day, and year) Oct 1-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55 yrs.	Oct. 3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman do

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER William S. Galloway

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Annie L. Brown

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Hospital Records (Address)

15 JAN 19 1930 By C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-17-30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1930, to Jan. 17, 1930, that I last saw him alive on Jan. 17, 1930 and that death occurred, on the date stated above, at 930 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Adhesions

Chronic Appendicitis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic Ileus Contributory

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Balto, Md

Did an operation precede death? yes Date of Jan. 11, 1930

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) E. A. Lusiny M. D.

, 19 (Address) 1213 Light St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL MOUNT. OLIVET CEM

DATE OF BURIAL 1/20 1930

20 UNDERTAKER ROBERT BROOKS AND SON

ADDRESS CALHOUN HOLLINS ST.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53099

CERTIFICATE OF DEATH

90 E 53099

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 Mosher ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Thomas

(a) RESIDENCE NO. 625 Mosher ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) md.

14 Informant Jane Thomas
(Address) 625 Mosher St

15 Filed ..., 19 ... Registrar

1 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17. 30

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1929, to Jan 17, 1930, that I last saw her alive on Jan 16, 1930, and that death occurred, on the date stated above, at 2.55 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ted Woolridge, M. D.

1-17-1930 (Address) 713 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	1-18 1930
20 UNDERTAKER David Easton	ADDRESS 916 Pa Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53100

CERTIFICATE OF DEATH

90 E 53100

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1924 Walbrook St., 15-21 Ward)

2-FULL NAME Margaret Lennon

(a) RESIDENCE NO. 1924 Walbrook St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? 71 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W. Lennon

6 DATE OF BIRTH (month, day, and year) Mar 17-1858

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	72	9	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Geo Byers

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Lennon

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Wm. McClelland
(Address) 1924 Walbrook

15 Filed JAN 8 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ....yrs. 6 mos. ....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

19 (Address) Coroner's

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Jan 30 1930

20 UNDERTAKER Harry W. Eblen

ADDRESS 1948 W. North Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53101

CERTIFICATE OF DEATH

8 v E 53101

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. # 1740 E. Federal ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick J. Beyer

(a) RESIDENCE NO. # 1740 E. Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 0 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine C. Beyer

6 DATE OF BIRTH (month, day, and year) Jan 3, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Christian Beyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Dora Jubb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs Katherine C. Beyer

(Address) # 1740 E. Federal St.

15 Filed C. HAMPSON JONES, M. D. Registrar

JAN 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16th, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 10, 1930, to January 16, 1930,

that I last saw h[illegible] alive on January 16, 1930

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Observation

(Signed) Albert C. Bowles M. D.

1/17 1930 (Address) 2075 Druid Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Jan 20, 1930.
20 UNDERTAKER John J. Cowan & Son	ADDRESS 901 Hollins

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53102

CERTIFICATE OF DEATH

90 E 53102

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 16-67 Ward)

2-FULL NAME Anna Mikalauckute

(a) RESIDENCE NO. 919 Rosedale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown . 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Leo Mikalauckute

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Regina —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Mrs Marie Warner
(Address) 919 Rosedale St

15 Filed ..... 19 H. LYDON JONES Registrar

JAN 18 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan. 17 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Kelly, M. D.

1/17. 1930 (Address) 239 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	June 20 1930
20 UNDERTAKER	ADDRESS
John J Cowan & Son	901 Hollins St

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Cor.—12-9-25—A Co—200 Bks.

E 53103

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53103

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (a) Springfield Hospital

2-FULL NAME John C. Cuff

(b) RESIDENCE NO. 1600 Division St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Florence

6 DATE OF BIRTH (month, day, and year) Oct 30 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa.

(State or country)

PARENTS

10 NAME OF FATHER Geo. Cuff

11 BIRTHPLACE OF FATHER (city or town) Pa.

(State or country)

12 MAIDEN NAME OF MOTHER Mary McShane

13 BIRTHPLACE OF MOTHER (city or town) Pa.

(State or country)

14 Informant Florence Cuff

(Address) 1600 Division St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubercular Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Monaco M. D.

(Coroner)

1/17 1930 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rocky Hill, Md Date of Burial 1/19 1930

20 UNDERTAKER Wm. H. Holland ADDRESS 1631 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C. HAMPSON JONES M.D.

JAN 19 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53104 X 90 E 53104

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1048 Eden ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Keene

(a) RESIDENCE NO. 1048 n Eden ST., WARD Cambridge Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE C | 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Keene

6 DATE OF BIRTH (month, day, and year) Feb. 18 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11 10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Minnie Walkins (Address) 1048 N. Eden St.

15 Filed JAN 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-16-30

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929 to Jan 16, 1930, that I last saw h alive on Jan 15, 1930 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cardio Renal

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo. D. Allen M. D.

1-16 1930 (Address) 508 Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md.

DATE OF BURIAL Jan. 16 1930

20 UNDERTAKER Mrs J. G. Socks

ADDRESS 1302 Jefferson

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53105 208 100-002 E 53105

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 208 N Schroeder St. 18-16 Ward)

2-FULL NAME Daisy Dorsey

(a) RESIDENCE NO. 208 N Schroeder St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13, 1929

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER William Dorsey

11 BIRTHPLACE OF FATHER (city or town) Parkville Md
(State or coun(try)

12 MAIDEN NAME OF MOTHER Bertha Hardman

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Bertha Dorsey
(Address) 208 N. Schroeder St

Filed JAN 18 1930 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, au-
(opsy or inquiry) find that said deceased came to his death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Cap. Bronchitis

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Ex Laudnor

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis? By History

(Signed) G C Glades M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Jan 18 1930
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 3224 Schroeder

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53106

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53106

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital

REGISTERED NO. 62

CITY OF BALTIMORE: (No. Lombard + Green ST. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Bunker

(a) RESIDENCE NO. 834 Warner ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-1-30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
2 days	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

JAN 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-1-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 1, 1930, that I last saw h... alive on Jan 1, 1930 and that death occurred, on the date stated above, at 11:50 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from cord

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. B. Johnson, M. D.

Jan. 19 30 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
VERSITY OF MARYLAND

DATE OF BURIAL ... 19...

20 UNDERTAKER
Dept. of Health.

ADDRESS JAN 17 1930

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 53107

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balt. General Hospital (ST.) (WARD)

REGISTERED NO. 16[illegible]

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby H Reynolds

(a) RESIDENCE NO. West Baltimore General Hospital ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan. 17, 1930

7 AGE — Years — Months — Days — If LESS than 1 day, hrs. 16 min. 46 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Paul Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Elizabeth Sweeny

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Paul Reynolds

(Address): 603 Longwood St

15 Filed: JAN 18 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1930, to Jan 18, 1930, that I last saw h in alive on Jan 18, 1930 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Asphyxia livida

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Intracranial hemorrhage

(duration) yrs. 16 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cisternal puncture

(Signed) J. V. Costagna, M. D.

, 19 (Address) W. Balto. Jan 18 30.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 18 1930

20 UNDERTAKER: George J Smith — ADDRESS: 532 Hollins

ORDER OF REGISTRAR must be filed with Undertaker before burial. See instructions on back of certificates.

JAN 18 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53108

CERTIFICATE OF DEATH

185 E 53108

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH U. S. Marine Hospital 2-4

City of Baltimore: (No. ..... St., ... Ward)

2-FULL NAME Gustav Ross (or Roos)

(a) RESIDENCE NO. 1633 Fleet St. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced? (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28, 1869

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
60	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer S. S. Hanley

9 BIRTHPLACE (city or town) .....
(State or country) Sweden

PARENTS

10 NAME OF FATHER Gustavus Ross (or Roos)

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Sweden

12 MAIDEN NAME OF MOTHER Louise Norstadt

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Sweden

14 Informant Hospital Records,
(Address) U. S. Marine Hospital

15 Filed ..... 19 ..... G. HAMPSON JONES, M. D.
Registrar

JAN 18 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia - following fracture of thigh bone - due to a fall. Accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John Mossman, M. D.

1/18, 1930 (Address) 2232 Rolande

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL H. Mayo Cemetery (Hampden)

DATE OF BURIAL Jan. 18 1930

20 UNDERTAKER E. LeRoy Stifflar, Inc.

ADDRESS 125 E. Northern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

(Froelicher)

E 53109 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53109

CERTIFICATE OF DEATH

1—PLACE OF DEATH Alumnae Lodge Goucher College REGISTERED NO. 50

CITY OF BALTIMORE: (No. 7 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hans Fröhlicher

(a) RESIDENCE NO. Chadford Apts. ST. Univ. Pkwy. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Fröhlicher

6 DATE OF BIRTH (month, day, and year) March 6, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Acting President

(b) General nature of industry, business, or establishment in which employed (or employer): Goucher College

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Solothurn Switzerland

PARENTS

10 NAME OF FATHER: Joseph Fröhlicher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Solothurn Switzerland

12 MAIDEN NAME OF MOTHER: Anna Buchser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Solothurn

14 Informant: Francis Fröhlicher (Son)

(Address) 503 Edgevale Rd. Roland Park

15 Filed JAN 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17 1930

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1927, to Jan 17, 1930, that I last saw him alive on Jan. 9, 1930, and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris. Arteriosclerosis

Chronic myocarditis

(duration) 10 yrs. mos.

CONTRIBUTORY (Secondary) Paroxysmal auricular fibrillation (duration) about 10 yrs. mos. ds.

Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Paul H. Clough, M. D.

1/18, 1930 (Address) 24 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Jan 20 1930
20 UNDERTAKER: Henry Wenkins Sons	ADDRESS: Oakland Md.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53110

CERTIFICATE OF DEATH

90 E 53110

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1609 Linden St. 11-24 (Ward)

2-FULL NAME Grace P. Benham

(a) RESIDENCE (Usual place of abode) The Cecil 1117 N. Eutaw Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Fem	Wh	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr Wm M. Benham

6 DATE OF BIRTH (month, day, and year) Oct 10-1885

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	44	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Parker

11 BIRTHPLACE OF FATHER (city or town) New York
(State or country)

12 MAIDEN NAME OF MOTHER Mary J. Graham

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Dr Wm M. Benham
(Address) The Cecil Apts.

15 Filed JAN 8 1930 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ...(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest ...(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis
Decidua
(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ? yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... Coroner, M. D.

Jan 17 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Jan 20 1930
20 UNDERTAKER John B. Spence	ADDRESS 1325 N. Carrollton Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

232454 E 53111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓ E 53111

REGISTERED NO. 12-50

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James R. Segar

(a) RESIDENCE NO. 84 E-27th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Segar

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None — do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va —
(State or country)

PARENTS

10 NAME OF FATHER John Segar

11 BIRTHPLACE OF FATHER (city or town) Va —
(State or country)

12 MAIDEN NAME OF MOTHER Mary Eyfrank

13 BIRTHPLACE OF MOTHER (city or town) Va —
(State or country)

14 Informant Friends —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 19 Roll. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18-30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1929, to Jan 18, 1930, that I last saw him alive on Jan 18, 1930, and that death occurred, on the date stated above, at 11 40 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia
Circulatory Failure
3 days.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate
(duration) 2 yrs. 7 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Cystoscopy—

(Signed) Wm. W. Kerr M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westpoint, Va

DATE OF BURIAL 1/18 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 Druid Hill Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bka.

E 53112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53112

REGISTERED NO. 66

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Union Memorial Hospital St., (Ward)

2-FULL NAME Lucretia B Quark

(a) RESIDENCE No. 3706 N. Charles St., Ward Salisbury Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Travers L. Quark

6 DATE OF BIRTH (month, day, and year) July 2 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Newton Burgoon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Fowler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Nancy A Quark
(Address) 3706 N Charles St

15 Filed JAN 13 1930. C. [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.

THE CAUSE OF DEATH* was as follows:

Coronary Thrombosis
Coronary
Suicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Morrison, M. D.

1930 (Address) 263 Poplar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salisbury Md	Jan 19 1930
UNDERTAKER John O Mitchell and Son	ADDRESS 1910 Eutaw Place

IMPORTANT: Physicians are requested to be careful in stating causes. Words should be used as nearly as possible in accordance with the standard of the International List of Causes of Death. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E. 53113.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

320 E 53113

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE; (No. 218 E- 25th St. 12-50 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy E. A. Adams

(a) RESIDENCE NO. Sharptown, Md. St. Ward Sharptown Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Adams

6 DATE OF BIRTH (month, day, and year) April 2nd 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	73	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Household duties

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Sharptown, Md.

(State or country)

PARENTS

10 NAME OF FATHER Isaac Cooper

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Julia A. Knowles

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Arthur E. Adams

(Address) 218 E. 25th Street

15 C. H. JONES, M. D.

Registrar

JAN 19 1930

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930 to Jan 18th, 1930.

that I last saw her alive on Jan 18th, 1930.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Endocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. L. Gordy M. D.

1-18. 1930 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sharptown, Md — Date of Burial Jan 20—1930

20 UNDERTAKER Bernard C. Hardesty — ADDRESS 1000 E. Pleasant

THIS BOX to be carefully supplied. And should be filled EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 53114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53114

1-PLACE OF DEATH.

City of BALTIMORE: (No. 918 Chauncey St. 3-59 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Blaustein (Blaustein)

(a) RESIDENCE NO. 918 Chauncey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca Blaustein

6 DATE OF BIRTH (month, day, and year): June 9-1882

7 AGE: Years 47 Months 7 Days 9 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Flour

(b) General nature of industry, business, or establishment in which employed (or employer): Dealer

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: Nathan Blaustein

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Dora Kahn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

Informant: Rebecca Blaustein

(Address): 918 Chauncey Ave

JAN 19 1930

C. RAMSAY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Fractured L. Leg

(Duration) ....yrs. ....mos. ....ds.

(Signed) John Morrissey M. D.

(Coroner)

1/18. 1930 (Address) 3832 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew Cem Date of Burial 1/19 1930

20 UNDERTAKER: Jack Lewis ADDRESS 1439 E Baltimore St

Exact statement of OCCUPATION is of plain terms, so that it may be properly classified.

See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E. 53115

E. 53115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 53115

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 Radnor Ave. ST. 47-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME May I. Sutton,

(a) RESIDENCE NO. 536 Radnor Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard S. Sutton,

6 DATE OF BIRTH (month, day, and year) May 6. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md,

PARENTS

10 NAME OF FATHER Wm. F. Garmhausen,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Chaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant R. Sterling Sutton

(Address) 536 Radnor Ave

15 Filed JAN 19 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 17 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1928, to Jan 17, 1930,

that I last saw h[illegible] alive on Jan 17, 1930

and that death occurred, on the date stated above, at 3.20 A m.

The CAUSE OF DEATH* was as follows: Ca Myocarditis, Chr Nephritis

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aunts Cardiac Substatus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. W. Bishop, M. D.

1/18, 1930 (Address) 501 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge

DATE OF BURIAL JAN 20 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Important. See instructions on back of certificate.

Spec.—2-29-25—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53116 — CERTIFICATE OF DEATH — 31 — E 53116

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 S. Wolfe St. ST. 7-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Portofee

(a) RESIDENCE NO. 235 S. Wolfe St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Symborski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Denver Daughter

(Address) 235 S Wolfe St

15 Filed JAN 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16-30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1930, to Jan. 16, 1930

that I last saw h[illegible] alive on Jan. 16, 1930

and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

1/18, 1930 (Address) 2529 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Jan. 20 1930

20 UNDERTAKER F W Bazewski ADDRESS 1930 Eastern

Spec.—2-29-28—L. F. S.—500 Bks.

E 53117

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53117

100-001

CERTIFICATE OF DEATH

E 53117

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore Gen. ST. 12-51 (WARD) Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Miller

(a) RESIDENCE NO. 322 W. 30th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary A. Nolan

6 DATE OF BIRTH (month, day, and year) ———

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent 60

(b) General nature of indastry, business, or establishment in which employed (or employer) Composing Room

(c) Name of employer A. S. Abell Company

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Isabel Firth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Fred A. Donovan
(Address) 339 E. 30th Street

15 Filed ___, 19___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-17-30

17 I HEREBY CERTIFY, That I attended deceased from 1-14, 1930, to 1-17, 1930,

that I last saw h[illegible] alive on 1-17, 1930

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ___ yrs. ___ mos. 7 ds.

CONTRIBUTORY (Secondary) Uremia - Advanced

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) Joseph Laukaitis, M. D.

19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 1/20 1930

20 UNDERTAKER Henry W. Mears and Son

ADDRESS 805 N. Calvert

Spec.—2-29-28—L. F. S.—500 Blks.

E.53118 ✓ E.53118

HEALTH DEPARTMENT—CITY OF BALTIMORE

48 E 53118

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-62

CITY OF BALTIMORE: (No. 3600 Edgewood Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John R. Cromwell

(a) RESIDENCE NO. 3600 Edgewood Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura E. Benson

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John G. Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Amanda Harman

13 BIRTHPLACE OF MOTHER (city or town) A. A. Co. Md. (State or country)

14 Informant Mrs. John R. Cromwell

(Address) 3600 Edgewood Road

15 Filed JAN 19 1930 19 Registrar: HAMPS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1929, to Jan. 17, 1930, that I last saw him alive on Jan. 15, 1930 and that death occurred, on the date stated above, at 2.45 p. m.

The CAUSE OF DEATH* was as follows:

Epithelioma of face

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) malnutrition and debility

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry R. Coffin M. D.

19 (Address) 1202 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemy.

DATE OF BURIAL Jan. 20 1930

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Eutaw Pl.

Important. See instructions on back of certificate.

Spec.—3-29-29—L. F. S.—500 Blks.

E 53119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53119 — REGISTERED NO. E 53119

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) 31

CITY OF BALTIMORE: (No. 25-32 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Reese

(a) RESIDENCE NO. 2212 Sidney ave., ST. Westport WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Hsd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER M. Payne

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Wash. (State or country) D.C.

14 Informant Hospital Records

(Address)

15 JAN 19 1930 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1930, to Jan. 17, 1930, that I last saw her alive on Jan. 17, 1930, and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Garnett Jr, M. D.

1-18, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 1/20 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Pond St

Spec.—2-29-28—L. F. S.—500 Blks.

V E53120

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53120

CERTIFICATE OF DEATH

31

E 53120

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Pearsnn

(a) RESIDENCE NO. 1017 N. Dallas st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
45	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 050

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Fannie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed JAN 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1928, to Jan. 17, 1930, that I last saw h[illegible] alive on Jan. 17, 1930 and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

1-17 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkridge Md

DATE OF BURIAL 1/20 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Coul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53121

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53121

CERTIFICATE OF DEATH

90

REGISTERED NO. E 53121

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 E Lombard ST. 2-5 WARD)

2—FULL NAME Philip Fribush

(a) RESIDENCE NO. 1127 E Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. — mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nail maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Fribush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Blume —

11 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Fribush
(Address) 1127 E Lombard st

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18/30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1925 to Jan. 18, 1930.

that I last saw him alive on Jan. 18, 1930

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis, Cardiac asthma, (duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Marcus, M. D.

19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern and

20 UNDERTAKER Sol Levinson & Bro

DATE OF BURIAL 1/19/1930

ADDRESS 1127 E Baltimore st

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E. 53122.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53122

CERTIFICATE OF DEATH

118-001

E 53122

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2421 Oak St (St.) 17-5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Scott Barrell

(a) RESIDENCE NO. 2421 Oak St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

3a If married, widowed, or divorced HUSBAND of (or WIFE of) Lucy Barrell

6 DATE OF BIRTH (month, day, and year) Mar. 15-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55	54	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lucy Barrell

(Address) 2421 Oak St

JAN 19 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930, to Jan 18, 1930, that I last saw him alive on Jan 15, 1930 and that death occurred, on the date stated above, at 10:10 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia (Inguinal)

(duration) yrs. 6 mos. ? ds.

CONTRIBUTORY (Secondary) Heavy Lifting

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) G. P. Hale, M. D.

19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Branch Va	Jan 19 1930

20 UNDERTAKER Robert F. Williams ADDRESS 1515 McElderry St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53123 E 53123 E 53123 E 53123 E 53123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 100-00

1—PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard + Green ST. 11-27 WARD)

2—FULL NAME Clarence Ingles

(a) RESIDENCE NO. 2019 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15. 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Clarence Ingles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Wingfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Ruth Ingles

(Address) 2019 W. Mulberry st

15 FILED JAN 19 1930 16 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929 to Jan 17, 1930

that I last saw him alive on Jan 17, 1930

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis

Bronchopneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Otitis media, ? adenitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Paracentesis Date of 1-13-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. B. Jutsum M. D.

Jan. 19 30 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jan 20 1930

20 UNDERTAKER John J. Fields 120 W Lombard — ADDRESS

JAN 19 1930

Important. See instructions on back of certificate.

Cor. 12-9-25—A Co.—200 Bks.

653124

F 53724

HEALTH DEPARTMENT—CITY OF BALTIMORE

653124

F 53724

CERTIFICATE OF DEATH.

REGISTERED NO. 188

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. John.S Hopkin.s Hosp't. 2-4 Ward)

2-FULL NAME Katarzyna Frankowska

(a) RESIDENCE NO. 605 S. Wolfe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Mr. Frankowska

(Address) 605 S. Wolfe St.

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 15 1930 193

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows*

Struck & knocked down by auto while lay walking at street intersection

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fractured Hip

Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Jones M. D. (Coroner)

1/19 1930 (Address) 1939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Wolfe & Fleet St

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial Jan 20 1930

20 UNDERTAKER ADDRESS John A Welch 1700 Thames St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AN 19 1930

Spec.—8-16-29—L. F. S.—100 Blks. E. 53125 ✓ E. 53125

232700 E 53125 90 E 53125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST. 26-11 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nelda Evans

(a) RESIDENCE NO. 3307 Noble st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 8 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 1921 (Unknown)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Fred Evans

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Susie Leybold

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 19 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-16-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1930, to Jan 16 1930, that I last saw her alive on Jan 16 1930 and that death occurred, on the date stated above, at 10 10 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart disease

Rheumatic Heart failure

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Benjamin E. Hooper, M. D.

19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elgin Hill Cem	Jan-20 19
20 UNDERTAKER C. Howard Evans	ADDRESS 38 E Fort Ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E. 53126.

53126

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 53126

24-34

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1648 Covington St. (St.) (Ward)

2-FULL NAME Ann C. Cromwell.

(a) RESIDENCE NO. 1648 Covington St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow.

5a If ~~married~~, widowed, ~~or divorced~~ (or) WIFE of Thomas I. Cromwell.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	77			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Francis Michael.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant George E. Cromwell. (son)
(Address) 1648 Covington st.

Filed JAN 19 1930 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Steinhardt M. D.

1/18. 1930 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Jan 20 1930
20 UNDERTAKER	ADDRESS
A. Howard Evans	28 E Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 53127

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53127

CERTIFICATE OF DEATH

1 1930 E 53127

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Mem. Hosp St. 17-49 Ward)

2-FULL NAME Melvin Kistner

(a) RESIDENCE NO. Edgewood Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec - 9 - 1917

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	12	1	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. H. Kistner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Pearl Gunther

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Wm. H. Kistner
(Address) Edgewood, Md.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an 1-19-30 (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Struck & knocked down by auto driven by Net & Ruth Driver Hom. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Pneumonia (duration) yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? Phila Rd at Edgewood

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis? Dr Hamer, M. D.

(Signed)

1-18. 1930 (Address) 3939 Mt Edy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon, Harford Co., Md	Jan. 21, 1930
20 UNDERTAKER	ADDRESS
Howard K. McComas	Abingdon, Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 53128

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53128

CERTIFICATE OF DEATH.

E 53128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 E. Churchill St. (St.) 22-33 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer H. King.

(a) RESIDENCE NO. 111 E. Churchill St. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Jany. 3rd. 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	0	18 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Elmer M. King.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth M. Wendel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Elizabeth M. King. (mother)
(Address) 111 E. Churchill St.

15 Filed ..... 19 1930 C. HUMPHREYS, M. D. Registrar
Fee $2.00

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany. 18th 1930

17

I HEREBY CERTIFY, That I attended deceased from January 16th, 1930, to January 18th, 1930, that I last saw h im alive on January 17th, 1930, and that death occurred, on the date stated above, at 8.05 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Heimhaldt, M. D.

1/18/30 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co Inc	Jan 20 1930
20 UNDERTAKER	ADDRESS
John F Penny	745 Lexington St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53129

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53129

CERTIFICATE OF DEATH

Brooklyn

REGISTERED NO. 25-75

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 Annabel St., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barney A White

(a) RESIDENCE NO. 532 Annabel Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 8 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma A White

6 DATE OF BIRTH (month, day, and year) April 27 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Barney B White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Holston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sawpit Maryland

14 Informant Mrs Emma A White

(Address) 532 Annabel ave

15 Filed JAN 19 1930 H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 8 1930 to Jan 18 1930, that I last saw h[illegible] alive on Jan 17 1930 and that death occurred, on the date stated above, at 5 25 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

+ Chronic Myocarditis

& Endocarditis (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs + Symptoms

(Signed) James E Peterman M. D.

(Address) 1228 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Jan 21 1930

20 UNDERTAKER John F Denny — ADDRESS 715 E. 9 St

Cor.—10-10-29—A Co.—100 Bks.

E. 53130.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-026 E. 53130

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1436 E Lexington St., 5-8 Ward)

2-FULL NAME Matilda Graham

(a) RESIDENCE NO. 1436 E Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alex Graham

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	98	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Matilda Smith
(Address) 1413 E Lexington

15 Filed JAN 9 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 8 1930

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Cardio Sclerosis

Senility

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) G. Glades, M. D.

1930 (Address) 1436 E Lex

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Hill Cem

DATE OF BURIAL Jan 12 1930

20 UNDERTAKER Samuel Ellwyn

ADDRESS 1436 Lex

DO NOT USE THIS SPACE. Physician or Undertaker may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E53131

HEALTH DEPARTMENT—CITY OF BALTIMORE

E53131

CERTIFICATE OF DEATH

REGISTERED NO. 188-703

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH St Agnes Hosp.

City of Baltimore: (No.) St. 13-52 Ward

2-FULL NAME Robt L. Pomeroy

(a) RESIDENCE NO. 3608 Keswick Rd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise Pomeroy 1853

6 DATE OF BIRTH (month, day, and year): Mar-25-1854

7 AGE: Years 76 Months 9 Days 22 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired RR
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Wm Pomeroy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Harry Pomeroy

(Address): 3608 Keswick Rd

15 Filed JAN 19 1930 H. Riley JONES M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Struck knocked down by auto.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Fract Skull & R. leg - (for) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wade Ave & Tredenick Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Frame M. D.

1/18 1930 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Front Royal Va

DATE OF BURIAL: Jan 20 1930

20 UNDERTAKER: Thanower & Son

ADDRESS: 3615 Chestnut

Spec. 1-10-21—MAT—1500 Blks.

E 53132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 53132 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (Ward) 12

2-FULL NAME Ella Blanche Watson

(a) RESIDENCE NO. 2205 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married.

If married, widowed, or divorced: HUSBAND of (or) WIFE of: E. Augustus J. Watson.

6 DATE OF BIRTH (month, day, and year): Sept 25 1879

7 AGE: Years 50; Months 3; Days 27; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: At Home Dorchester Co Md

9 BIRTHPLACE (City or town) (State or country): Dorchester Co Md

PARENTS

10 NAME OF FATHER: Joseph H. Leg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dorchester Co Md

12 MAIDEN NAME OF MOTHER: Ella Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dorchester Co Md

14 Informant: E. J. Watson

(Address) 2205 E. Preston St

15 Filed JAN 19 1930 C. NAMMAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13, 1930, to Jan. 18, 1930, that I last saw her alive on Jan 18, 1930, and that death occurred, on the date stated above, at 3.25 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Unknown type)

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) M. B. Hendricks, M. D.

1/18, 1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Jan 21 1930

20 UNDERTAKER: Joseph L. Cook

ADDRESS: 803 N. Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E53133

F 53133

S—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E53133 F 53133

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Chesterton md 1641 Ec WARD)

2-FULL NAME Susan Virg. Dewey.

(a) RESIDENCE NO. Chesterton. Md Kent Co ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jan 11 1930

7 AGE: Years — Months — Days 7 If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED: —

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER Earl. D. Dewey

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER Margaret Litsinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Earl. D. Dewey. (Address) Chesterton md.

15 Filed JAN 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 1930 to Jan 19 1930 that I last saw h alive on Jan 19 1930 and that death occurred, on the date stated above, at 6 45 A m.

The CAUSE OF DEATH* was as follows:

Congenital stenosis of Duodenum

(duration) yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? St Josephs Hospital

Did an operation precede death? yes Date of 1/18/30

Was there an autopsy? yes. What test confirmed diagnosis? Clinical & Autopsy

(Signed) J Robert Bardo, M. D.

1930 (Address) 3105 Belair Rd St Josephs Hospital

*State the Disease Causing Death, or in deaths from violent causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chesterton md Kent Co — DATE OF BURIAL: Jan 20 1930

20 UNDERTAKER: Geo. F. Ruth — ADDRESS: Chestertown Md

CAUSE OF DEATH IN PLAIN TERMS. See instructions on back of certificates. IT IS VERY important.

E53134

E53134

E 53134

100-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 2550 ST. Robb (WARD) 9-4a

2-FULL NAME Anna B. Marvell

(a) RESIDENCE NO. 2550 ST., Robb WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John S. Marvell

6 DATE OF BIRTH (month, day, and year): Sept. 12, 1846

7 AGE: Years 83 Months 4 Days 3 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dover, Del.

PARENTS

10 NAME OF FATHER: John Marvell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dover, Del.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dover, Del.

14 Informant: Robert C. Floyd

(Address): 2550 Robb St.

15 Filed JAN 28 1930 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929 to Jan. 15, 1930.

that I last saw her alive on Jan. 15, 1930

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Senility - Broncho-Pneumonia (duration) ..... yrs. mos. 17 ds.

Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence.

(Signed) Wm B. Seybert, M. D.

, 19 (Address) 280 E Stanford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arlington Cem Merchantville

DATE OF BURIAL: Jan 29, 30

20 UNDERTAKER: W. J. Fleckner Sons

ADDRESS: North St Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53135

E 53135

E 53135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 53135

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Milton Ave. WARD) 9-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Keimbach

(a) RESIDENCE NO. 523 N. Milton Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 8 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Keimbach

6 DATE OF BIRTH (month, day, and year) Apr 28 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	63	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seafood Bus.

(b) General nature of Industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Dail. Meads. (Address) 523 N. Milton Ave.

15 Filed JAN 20 1930 19 C. HEMPELMANN, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 8 1929 to Jan 17 1930 that I last saw h in alive on Jan 17 1930 and that death occurred, on the date stated above, at 10.35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 6 mos.

CONTRIBUTORY (Secondary) Myocardial Insufficency (duration) 1 mos.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) Wm G. Geyer, M. D.

19 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL Jan. 20 1930

20 UNDERTAKER Wm Pickner & Son ADDRESS North & Pa

E. 53136

Spec.—1-10-21—M&T—1500 Blks.

E. 53136 HEALTH DEPARTMENT—CITY OF BALTIMORE 10-00 53136

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Sydenham Hospital WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME June Dietz

(a) RESIDENCE NO. 1611 Gorsuch ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 16, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Doris Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) George Dietz 1611 Gorsuch Ave

Filed JAN 20 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 18, 1930, that I last saw h alive on Jan 18, 1930, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Tonsillar + Pharyngeal)

(duration) 0 yrs. 0 mos 11 ds.

CONTRIBUTORY (Secondary) Acute Diphtheritic Myocarditis (duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? 1611 Gorsuch Ave

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Jobe, M. D.

1-18, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 1/20 1930

20 UNDERTAKER J. J. Tucker Sons

ADDRESS —

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—(2-23-21—E.B.R.S.—400 Blks.

E 53137 E. 53137

E 53137 E 53137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1304 N. Bentalou St., 15-68 Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie F. Flandorffer

(a) Residence No. 1304 N. Bentalou St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas. Flandorffer

6-DATE OF BIRTH (month, day and year) April 5, 1881

7-AGE, 48 yrs. 9 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... —

(c) Name of employer..... —

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, William Knott

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Frederick, Md.

12-MAIDEN NAME OF MOTHER, Isabell Hutchins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore County

14- (Informant) Charles Flandorffer (Address) 1304 N. Bentalou St.

15- Filed ..... 193... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 17, 1930

I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1927 to Jan. 17, 1930 that I last saw h[e]r alive on Jan. 17, 1930 and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(Duration) 20 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John D. Quinn, M. D.

1-18, 1930 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Woodlawn Cem DATE OF BURIAL, Jan 20, 1930

20-UNDERTAKER. Wm. J. Tickner & Son ADDRESS Mt. Pleasant

Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Merrick

E. 53138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 53138

E 53138

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 626 W Lanvale ST. 22-30 WARD)

2—FULL NAME Benjamin Merrick

(a) RESIDENCE NO. 626 W Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Merrick

6 DATE OF BIRTH (month, day, and year) Oct. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	10	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer Hess & Co.

9 BIRTHPLACE (city or town), (State or country) Raleigh N.C.

PARENTS

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country)

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country)

14 Informant Mary Merrick

(Address) 626 W Lanvale St

15 Filed JAN 20 1930 19 RLM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/17/30

17 I HEREBY CERTIFY, That I attended deceased from 1/7, 1930, to 1/17, 1930, that I last saw h[illegible] alive on 1/17, 1930, and that death occurred, on the date stated above, at 7 00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. — mos. 28 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D. H. Connell M. D.

1/18, 1930 (Address) 620 Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Jan 20 1930

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Hanover

Important. See instructions on back of certificate.

Spec.—16-29—L. F. S.—100 Bks.

E 53139

HEALTH DEPARTMENT—CITY OF BALTIMORE

2325 59 F 63139

CERTIFICATE OF DEATH

100-001 F 63139

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Bland

(a) RESIDENCE NO. 924 N. Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
F	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Bland

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress out

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ellen Blegeast

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Friend

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. J. LAMPRECHT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 17/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to Jan 17, 1930, that I last saw h[illegible] alive on January 17, 1930 and that death occurred, on the date stated above, at 5 45 p m.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia following Hystero myomectomy, 5 days duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ether anesthesia, 3 hours, Pneumonia on Jan. 13, 1930. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In place of death.

Did an operation precede death? yes Date of 1-12-30.

Was there an autopsy? yes.

What test confirmed diagnosis? Symptoms, X-rays, etc.

(Signed) Raymond C. Spurier M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va. DATE OF BURIAL Jan 21 1930

20 UNDERTAKER Chris T. Johnson ADDRESS 406 N. Caroline St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

B 53140

CERTIFICATE OF DEATH

B 53140

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 S. Dallas St. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. King

(a) RESIDENCE NO. 31 S. Dallas St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col.	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie King

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachael Rhodes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Smith

(Address) 31 N. Dallas St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/16/30

17 I HEREBY CERTIFY, That I attended deceased from 1/3, 30, to 1/16, 30, that I last saw him alive on 1/15, 30 and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Intraocular Parenchymatous nephritis. (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arthritis Deformans (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Microscopic

(Signed) [illegible] M. D.

1/16, 30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 1/20 1930

20 UNDERTAKER Chas. H. DeLauney ADDRESS 416 N. Carey St.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53141

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53141

CERTIFICATE OF DEATH

90 E 53141

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 741 N. Central Ave ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Shipley

(a) RESIDENCE NO. 741 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 18 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	39 40	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Richard Shipley

11 BIRTHPLACE OF FATHER (city or town) Balto - Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Burke

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mrs Mary Shipley

(Address) 741 N. Central Ave

15 Filed JAN 20 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/18/30

17 I HEREBY CERTIFY, That I attended deceased from 9/24, 1929, to 1/18, 1930

that I last saw her alive on 1/18, 1930

and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Benjamin Wolk, M. D.

1/18, 1930 (Address) 2030 W. Lanvale Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Jan 21 1930

20 UNDERTAKER Henry Hoen & Sons Inc.

ADDRESS 1311 E Eager

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53142.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53142

CERTIFICATE OF DEATH

29 ✓ E 53142

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1031 N Carlton ST. (WARD) 18-M

2—FULL NAME Walter Larkins

(a) RESIDENCE NO. 1031 N Carlton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Sing

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Ofc

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Larkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Cinderella Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary Deale
(Address) 1031 N Carlton

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1927, to June 17, 1930, that I last saw h.... alive on June 16, 1930, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

& Pers Convulsions

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J Norwood, M. D.

June 17, 1930 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL June 20 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3221 Sherwood Ave

Important. See instructions on back of certificate.

E. 53143

Spec.—1-10 22—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE 53143

53143

CERTIFICATE OF DEATH.

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5706 Greenhill ave ST.) (WARD 4-4)

2-FULL NAME William F. Inglehardt (INGLART)

(a) RESIDENCE NO. 5706 Greenhill ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 4 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth K. Inglart.

6 DATE OF BIRTH (month, day, and year) Aug. 26th 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tool Dresser

(b) General nature of Industry, business, or establishment in which employed (or employer) Bethl. Steel Corp.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Philip H. Inglart

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Neumeyer

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Elizabeth K. Inglart (Wife)

(Address) 5706 Greenhill Ave

15 Filed JAN 29 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3 1930 to Jan. 18 1930, that I last saw him alive on Jan 18 1930, and that death occurred, on the date stated above, at 5 45 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate
Myocarditis

(duration) 1 yrs. mos de.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 de.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/13/30

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H H Barranco, M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery.

DATE OF BURIAL Jan 21st 1930

20 UNDERTAKER Lilly & Sons Inc.

ADDRESS 403 S. Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53144

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53144

E 53144

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Kenwood Ave ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Schmitt.

(a) RESIDENCE NO. 111 Kenwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	68	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Schmitt

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Gertrude Desch

12 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr Joseph Zeiler

(Address) 708 Elmwood Road

15 Filed JAN 20 1930, 19 R.H.P. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929, to Jan 18, 1930, that I last saw h— alive on Jan 17, 1930 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Insufficiency

(duration) yrs. 2 mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Edward Bevan, M. D.

1/18, 1930 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Jan 21 1930

20 UNDERTAKER Lilly & Zeiler Inc

ADDRESS 403 S. Wolfe St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

- 6.53145

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 53145

CERTIFICATE OF DEATH

E 53145

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 570 Radnor Ave. ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Louis Wheeler.

(a) RESIDENCE NO. 570 Radnor Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ivy Iona Heim Wheeler.

6 DATE OF BIRTH (month, day, and year) March 6 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Fitter 073

(b) General nature of industry, business, or establishment in which employed (or employer) R. R. Shop.

(c) Name of employer Penna. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Andrew T. Wheeler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER L. Macanhammer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. Ivy Heim Wheeler.

(Address) 570 Radnor Ave.

15 Filed 2 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 22nd 1929 to Jan 17th 1930

that I last saw h[illegible] alive on Jan 16th 1930

and that death occurred, on the date stated above, at 11.45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 1 yrs. [illegible] mos. [illegible] da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Leptomeningeal Exam

(Signed) George Logan Jr M. D.

1/18/1930 (Address) 1400 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	1/20/30

20 UNDERTAKER C. Vernon Lemmon

ADDRESS 4513 Park Heights Ave.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH

E 53146

REGISTERED NO. E 53146

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1324 Hull ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Cadden

(a) RESIDENCE NO. 1324 Hull ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 19. 30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓				12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Thos. Jas. Cadden

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Fallon

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Margaret Cadden

(Address) 1324 Hull St

15 Filed JAN 20 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19, 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 19 30, to Jan 19, 19 30

that I last saw h W alive on Jan 19, 19 30

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

5 months
Pneumonia
Lobar, 2 minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) Thos J. Stevens, M. D.

1 19, 1930 (Address) 2787 Halford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Jan 20 1930

20 UNDERTAKER Chas. L. Stevens

ADDRESS 130 E Fort Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

53147 53147 53147

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Sinai Hospital St., 15-61 (Ward)

2-FULL NAME Sarah Wise

(a) RESIDENCE NO. 3511 Fairview Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Wise

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
About 49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E Balto. St.

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

? (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Bris Sholom Hall

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ... M. D.

1/20/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Ist Cemet. — DATE OF BURIAL 1/20/30

20 UNDERTAKER Jack Lewis 1439 — ADDRESS E Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53148

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 Madison ave St.) (WARD)

2—FULL NAME Billy Holmes

(a) RESIDENCE NO. 1317 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 23. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	✓	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER John Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Carrie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Holmes

(Address) 1317 Madison ave

15 Filed JAN 20 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-19-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Jan 19, 1930, that I last saw h... alive on Jan 19, 1930 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Mal nutrition

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Calvin B. L. Compto, M. D.

19 (Address) 1113 n Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Jan 20 1930

20 UNDERTAKER Thomas & Kelson

ADDRESS 1303 Pennsylvania

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E-53149

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53149

CERTIFICATE OF DEATH

74-001

E 53149

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Etting ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Rice Divine

(a) RESIDENCE NO. 1717 Etting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Divine

6 DATE OF BIRTH (month, day, and year): Centenarian

7 AGE: 70 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Mathews Co., Va

PARENTS

10 NAME OF FATHER: Richard Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Rosa Front

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: George Divine

(Address) 1717 Etting St

15 FILED JAN 29 1930 19 H. E. [illegible] M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 16/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 14-30 to Jan 16-30,

that I last saw her alive on , 19

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Arthritis

(duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. U. Cardozo, M. D.

1-16-30 (Address) 524 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Jan 29 19 30

20 UNDERTAKER: Thomas E Kelson

ADDRESS: 1303 Brentmore

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53150

CERTIFICATE OF DEATH

90

E 53150

1—PLACE OF DEATH

REGISTERED NO.

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. (R.) ST. WARD) 1427

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest (R.) Taylor

(a) RESIDENCE NO. 1409 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) April 20, 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 70

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard C. Taylor

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Recorded (Address) BALTIMORE CITY HOSPITALS

15 Filed ——, 19 —— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-30

17 I HEREBY CERTIFY, That I attended deceased from 1-14, 1930, to 1-18, 1930, that I last saw him alive on 1-18, 1930 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchitis, chronic

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin W. McLean, M. D.

1-19, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Jan 22 1930
20 UNDERTAKER Jesse H. Reddent	ADDRESS 1136 N. Bridge Ave

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 53151 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53151

REGISTERED NO. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3425 E Lombard (St.) 16-37 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Doerfler

(a) RESIDENCE. NO. #3425 E Lombard St ST., WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 18-1930

7 AGE: Years Months Days: FT

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 3425 E Lombard St Baltimore

PARENTS

10 NAME OF FATHER Ferdinand Doerfler

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Florence Mary Funk

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

4278

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Jan 18, 1930, that I last saw he alive on Jan 18, 1930, and that death occurred, on the date stated above, at 5 hours m.

The CAUSE OF DEATH* was as follows:

5 Month Miscarriage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John G Leyer M. D.

, 19 (Address) 186 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL JAN 20 1930

Address

Commissioner Health

JAN 20 1930

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 53152 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53152

Registered No. 161

1-PLACE OF DEATH

City of BALTIMORE: (No. 1736 W. Lexington St. 1-9-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Boy Brown

(a) Residence No. 1736 W. Lexington St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan. 17 1930

7-AGE. — yrs. — mos. — ds.

If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Balto. (State or Country), Md

PARENTS.

10-NAME OF FATHER, Nelson Brown

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Clara Cowell

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) Archie R. Cohen

(Address) 406 N. Wolfe St.

15- Filed JAN 20 1930 193 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-17-30

17- I HEREBY CERTIFY, That I attended deceased from Jan 17 1930 to Jan 17 1930

that I last saw him ~~alive~~ dead on Jan 17 1930

and that ~~death~~ Stillborn occurred, on the date stated above, at 7:29 p.m.

The CAUSE OF DEATH* was as follows:

~~Prematurity~~

Prematurity. (30 weeks)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Adam Schaeffer M. D

1/17 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL. 19

20-UNDERTAKER. Samuel Hampson Jones, M. Commissioner of Health.

ADDRESS JAN 1 0 1930

instructions on back of certificates.

Spec.—6-9-15—H. P. Co.—1000 Bks.

Rollison

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

161-001

CERTIFICATE OF DEATH.

REGISTERED NO. E 53153

1-PLACE OF DEATH E 53153

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 205 N Emmard St. (Ward) 11

2-FULL NAME Baby Rollinson

(a) RESIDENCE. NO. 205 N Emmard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fml

4 COLOR OR RACE: whi

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/15/30

7 AGE — Years: — Months: — Days: 3 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bab

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Roy Rollinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mamie Ozmin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Roy Rollinson (Address) 205 N Emmard

15 Filed ... 19 ... Registrar

JAN 20 1930 ... Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1930

17 I HEREBY CERTIFY, That I attended deceased from June 18, 30, to June 17, 19 30, that I last saw h... alive on June 17, 19 30, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Prematus Birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

, 19 (Address) 2538 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS JAN 18 1930

FOR WM. R. WOODALL

TION is very important. See instructions on back of certificates.

JAN 20 1930

$2.75

Spec.—8-16-29—L. F. S.—100 Bks.

233151

E 53154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 47 E 53154

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Myrtle Wheatley

(a) RESIDENCE NO. Sharpstown Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel H. Wheatley

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER John Colbourn

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Eliz. Carroll

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 18, 1930, that I last saw her alive on Jan 18, 1930 and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

bronchopneumonia metastasis of cancer of breast

metastasis in chest

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sharpstown Md

Did an operation precede death? yes Date of 2 mos ago

Was there an autopsy? no

What test confirmed diagnosis? X-ray of chest

(Signed) Asher Dichtchy, M. D.

1-18, 1930 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sharpstown Md- BC&A to Forestville auto to Sharpstown

DATE OF BURIAL Jan 20 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Eighth St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53155

CERTIFICATE OF DEATH

90 ✓ E 53155

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 S. Poppleton 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James C Grimes

(a) RESIDENCE NO. 408 S. Poppleton STREET

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa E Grimes

6 DATE OF BIRTH (month, day, and year) Sept 11 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	87	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va

PARENTS

10 NAME OF FATHER James G. Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Anne Clifford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Frederick N Grimes

(Address) 711 W Baltimore Md

15 Filed JAN 20 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1930

17 I HEREBY CERTIFY That I attended deceased from Dec. 16, 1929, to Jan 18, 1930, that I last saw h alive on Jan 18 1930 and that death occurred, on the date stated above, at 4 50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John A Shearouthy M. D.

1/19 30 (Address) 642 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Jan 21 1930

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53156 ✓ E 53156

101-001

E 53156

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Wright

(a) RESIDENCE NO. 914 Jordan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Wright

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
1 56	55	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Danville

(State or country) Va

PARENTS

10 NAME OF FATHER Henry Wright

11 BIRTHPLACE OF FATHER (city or town) Danville

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Martha James (daughter)

(Address) 914 Jordan Street

15 Filed , 19 Registrar

JAN 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930 to Jan 18, 1930

that I last saw h~~e~~ alive on Jan 18, 1930

and that death occurred, on the date stated above, at 11:10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

. 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-20 1930

20 UNDERTAKER Mrs Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53157 (REGISTERED NO.)

E 53157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 933 Hanover st. (Ward) 23-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elisabeth Waldschmidt

(a) RESIDENCE. No. 933 Hanover st. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 4 mos. 3 ds. How long in U. S., if at foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Waldschmidt

6 DATE OF BIRTH (month, day, and year) Sept. 14/1851.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Nagengast

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elisabeth Kutcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dr. Henry Waldschmidt
(Address) 933 Hanover st.

15 Filed [illegible] 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18/30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1/29, 19..., to Jan. 18/30, 19..., that I last saw h.er alive on Jan. 18/30, 19..., and that death occurred, on the date stated above, at 4.15 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Dilitation

(duration) 3 yrs. Nephritis.

CONTRIBUTORY (Secondary) Chronic Paranchymatous (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Waldschmidt M.D.

Jan. 18/30 933 Hanover st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	1-21 1930
20 UNDERTAKER	ADDRESS
E & B Harle	115 E. West St.

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bl...

E 53158

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53158

CERTIFICATE OF DEATH

74-0

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 E Preston ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Davis

(a) RESIDENCE NO. 906 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wife Robert Davis

6 DATE OF BIRTH (month, day, and year) 11-26-1851

7 AGE	Years	Months	Days 23	If LESS than 1 day, ...hrs. or ...min.
✓	68	1	25?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) House wife

(c) Name of employer

9 BIRTHPLACE (city or town) York

(State or country) Pa

PARENTS

10 NAME OF FATHER John Hilbert

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Germany

12 MAIDEN NAME OF MOTHER ? Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Germany

14 Informant Agnes Beatty

(Address) 906 E Preston

15 Filed JAN 20 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19/30

17 I HEREBY CERTIFY, That I attended deceased from 1/12/, 1930, to 1/20/, 1930,

that I last saw her alive on 1/20, 1930

and that death occurred, on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ...yrs. ...mos. 7 ds.

CONTRIBUTORY (Secondary) ...(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) S. Lee Haynes, M. D.

1/20, 1930 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. York Pa

DATE OF BURIAL 1/23 1930

20 UNDERTAKER H. Rauch

ADDRESS Lafayette

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001 E 53159

REGISTERED NO. E. 53159

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Clarence (Susan) Rank

(a) RESIDENCE NO. 1419 Market St. ST. Harrisburg Pa WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence Rank

6 DATE OF BIRTH (month, day, and year) March 25 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	48	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanoverdale Pa

PARENTS

10 NAME OF FATHER Daniel Shaenk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middletown Pa

12 MAIDEN NAME OF MOTHER Susan Rider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Middletown Pa

14 Informant Hospital Records (Address)

15 Filed ... 19... C. HUNTER JONES M. D. Registrar

JAN 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 20, 1930, that I last saw h[illegible] alive on Jan 20, 1930, and that death occurred, on the date stated above, at 3:20 A m.

The CAUSE OF DEATH* was as follows:

Ventral Hernia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Place of abode

Did an operation precede death? yes Date of 1-11-30

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Jane S. Fagan M. D.

Jan 20, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL East Harrisburg Cem Harrisburg Pa — DATE OF BURIAL Jan 20 1930

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul St.

Important. See instructions on back of certificate.

E 53160 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

166 E 53160

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia Autry

(Residence in Baltimore: No. 11 E. Chase St / Emb. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, OR DIVORCED, (Write the word) ?

6-DATE OF BIRTH, ..., (Month) 1 (Day) ..... (Year)

7-AGE, 30 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Nurse (b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Indiana

PARENTS:

10-NAME OF FATHER, Julius Gray

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Mary Davis

13-BIRTHPLACE OF MOTHER (State or Country), Penna

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mercy Hospital

(Address) .....

15- Filed JAN 29 1930 101... Pat ..... Registrar.

C. HALLOCK JONES, M. D.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan 20 (Month) / 30 (Day), 191... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... Suicide by inhalation of Illuminating Gas

..... (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Pleurisy

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) ..... (Coroner) M. D.

Jan 21 1930 (Address) 1639 Bank

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Scranton Pa

DATE OF BURIAL. Jan 24, 1930

20-UNDERTAKER Henry T. Jenkins Lo

ADDRESS Balt Md

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E. 53161

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53161

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteer Hospital ST., 846 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Schweinsberg

(a) RESIDENCE No. 1437 Patterson Park ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late John Schweinsberg

6 DATE OF BIRTH (month, day, and year) July 25-1853

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
77	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Just

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Baer

(Address) 1437 E. Patterson Pk

15 Filed JAN 20 1930 R.M.L. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-3, 1930, to 1-18, 1930.

That I last saw her alive on 1-18, 1930,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Fracture of Femur

(duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death? 1437 Patterson Pk. ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray of hip

(Signed) A. F. Conrey M. D.

1-17-1930 (Address) Volunteer Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jan. 20, 30

UNDERTAKER Harry N. Witzke, 410 — ADDRESS Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Eugene Feller, M.D. 037

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53162

E 53162

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 Ringold ST. 21-79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Stewart

(a) RESIDENCE NO. 311 Ringold ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred five mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Stewart

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Susie Hill

(Address) 628 N Bruce St.

15 Filed 1-20, 1930 CLAYTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19/30

17 I HEREBY CERTIFY, That I attended deceased from 1/16/30, to 1/19/30, that I last saw him alive on 1/19/30, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Acute Bronchitis (Influenza)

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. [illegible] Bowley, M. D.

1/19/30 (Address) 908 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-20-30

20 UNDERTAKER Samuel Cohen

ADDRESS 916 Penna Ave

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53163

90 E 53163

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 4-25 WARD)

2—FULL NAME Julia Davis

(a) RESIDENCE NO. 207 Arch St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: ? Borum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia?

12 MAIDEN NAME OF MOTHER: Meriah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Records of

(Address): Balto. City Hospitals, M.

15 Filed JAN 20 1930 HAROLD C. CURTIS, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-17-30

17 I HEREBY CERTIFY, That I attended deceased from 1-15-30, 19..., to 1-17-30, 19..., that I last saw h... alive on 1-17-30, 19..., and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W McClean M. D.

1-18, 1930 Address Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	1-20-30
UNDERTAKER: Daniel Eaton	ADDRESS: [illegible]

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53164 90 E 53164

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ST. 10-12 WARD)

2—FULL NAME Laura Jenkins

(a) RESIDENCE NO. 1444 E. Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	bet. 60 & 67 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

14 Informant Accurate
(Address) BALTIMORE CITY HOSPITALS

15 Filed JAN 20 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-30

17 I HEREBY CERTIFY, That I attended deceased from 5-5, 19 27, to 1-18, 19 30, that I last saw her alive on 1-18, 19 30 and that death occurred, on the date stated above, at 3 40 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 3? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McClean, M. D.

BALTIMORE CITY HOSPITALS

1-19, 19 30 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery — DATE OF BURIAL Jan 22 19 30

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53165

E 53165

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 519 N. Monroe ST. (WARD) W-7

2—FULL NAME Frances R. Williams

(a) RESIDENCE NO. 519 N. Monroe ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo L. Williams

6 DATE OF BIRTH (month, day, and year) June 30. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charles Co., Md.

PARENTS

10 NAME OF FATHER Thos. Hagen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co., Md.

12 MAIDEN NAME OF MOTHER Georgeanna Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co. Md.

14 Informant Mrs. John J. Smith

(Address) 519 N. Monroe St.

15 FILED JAN 20 1930, 19

C. HAMPSON JONES, M. D. Registrar

Per A.C.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 23, 19 29, to Jan. 17, 19 30, that I last saw h alive on Jan. 17, 19 30 and that death occurred, on the date stated above, at 7:02 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL Jan 20 1930

20 UNDERTAKER Margaret H. Flynn

ADDRESS 1422 Light St.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53166 +49 E 53168

CERTIFICATE OF DEATH

1—PLACE OF DEATH Church Home & Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore Md 629 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Maria Wilson

(a) RESIDENCE NO. 715 Murdock Road ST., WARD Balto Co Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 1 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Guy K. Wilson

6 DATE OF BIRTH (month, day, and year) Dec 15 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Edward Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bucktown

12 MAIDEN NAME OF MOTHER Annie M. Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Guy K. Wilson (Address) 715 Murdock Road

15 JAN 0 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1929, to Jan 17, 1930, that I last saw h[illegible] alive on Jan 17, 1930 and that death occurred, on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH* was as follows:

Multiple sclerosis (?)

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? In Patient's home

Did an operation precede death? Yes Date of 10/21/29

Was there an autopsy? Yes - Partial

What test confirmed diagnosis?

(Signed) Chas B. Wallace M.D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Jan 21 1930
20 UNDERTAKER	ADDRESS
Jos Joerdens Son	2173 Pa

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 53167

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53187

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hospital (St.) 8-40 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Pauline Devereaux

(a) RESIDENCE NO. 3423 Ellwood Ave (St.) (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44.4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Paul M. Devereaux

6 DATE OF BIRTH (month, day, and year): Mar. 20 1896

7 AGE: Years 33 Months 9 Days 29

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: W J Cornwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Gore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Paul M. Devereaux

15 C. HAMPSON JONES, M. D. Registrar

Dated 19 Jan 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/19/30 19

17 I HEREBY CERTIFY, That I attended deceased from 1/12/30 19 to 1/19/30 19, that I last saw her alive on 1/12/30 19, and that death occurred, on the date stated above, at 7.26 A m.

The CAUSE OF DEATH* was as follows:

acute appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Cor pulmonale

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/13/30

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) L. Pitts Barda M. D.

19 (Address) 3105 Belair Rd

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jan 24 1930

20 UNDERTAKER: Howard McComas — ADDRESS: Atty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

20 1930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53168 46 **E 53168**

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 N. Paterson Park Ave. WARD) 12

2-FULL NAME Clare E. Hammel.

(a) RESIDENCE NO. 1212 N. Paterson Park Av. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 ~~Single~~, Married ~~Widowed~~, ~~or Divorced~~, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Hammel.

6 DATE OF BIRTH (month, day, and year) Nov 6/1889.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	40	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Michael Schiefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Susan Kessler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles E. Hammel
(Address) 1212 N. Paterson Park Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1929, to Jan 15, 1930, that I last saw her alive on Jan 17, 1930, and that death occurred, on the date stated above, at 6 25 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bottom of appendages

(duration) ..... yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Oct 25/29

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests

(Signed) Clark G. Simpson M. D.

1930 (Address) 1613 E. Monument Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Jan 21. 1930

20 UNDERTAKER Geo. J. Roth

ADDRESS 1735 Hayford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. PARTICULAR ATTENTION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53169 + 47 E 53169

CERTIFICATE OF DEATH

1—PLACE OF DEATH The Church Home & Infirmary REGISTERED NO. .....

CITY OF BALTIMORE: No. N. Broadway ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Helen Ingram

(a) RESIDENCE NO. 511 Clayton Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 24 ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Ray F. Ingram

6 DATE OF BIRTH (month, day, and year) June 12, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Westfield (State or country) New Jersey

PARENTS

10 NAME OF FATHER Lindsey Wooley

11 BIRTHPLACE OF FATHER (city or town) Matchuan (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Estelle Van Middlesworth

13 BIRTHPLACE OF MOTHER (city or town) Summerville (State or country) New Jersey

14 Informant Mr. Ray F. Ingram (Address) 511 Clayton St. Waynesboro Pa.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20/30

17 I HEREBY CERTIFY, That I attended deceased from December 26, 1929, to January 20, 1930, that I last saw h.. alive on January 20, 1930 and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of both breasts with carcinomatosis

(duration) ..... yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Waynesboro Pa

Did an operation precede death? Yes Date of Dec. 30, 1929

Was there an autopsy? No

What test confirmed diagnosis? History, Physical, Pathological clinical findings on autopsy tissues was given

(Signed) J. Brooke Hewitt, M. D.

Jan. 20, 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waynesboro Green Hill Cemetery

DATE OF BURIAL 1/23 1930

20 UNDERTAKER Walter J. Stone

ADDRESS Waynesboro Pa.

Important. See instructions on back of certificate.

JAN 20 1930 RRH

Spec.—2-29-28—L. F. S.—500 Blks.

E 53170

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53170

CERTIFICATE OF DEATH

REGISTERED NO. 24-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2708 Hugo Ave. ST. 9-46 (Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest C. Leimbach

(a) RESIDENCE NO. 2708 Hugo Ave. ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida B. Leimbach

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	57	1	24 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Charles C. Leimbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Brandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ida B. Leimbach

(Address) 2708 Hugo Ave.

15 Filed JAN 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 17, 1930, that I last saw h... alive on Jan 17, 1930 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 day

CONTRIBUTORY (Secondary) High blood pressure

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. Zimmerman M. D.

1-19-1930 (Address) 2708 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem — DATE OF BURIAL: Jan. 22 1930

20 UNDERTAKER: Wm. C. Black — ADDRESS: 921 N. Broadway

Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53171

CERTIFICATE OF DEATH.

E 53171

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 451 Putnam Place St. 12-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth L. Tracy

(a) Residence No. 451 Putnam Place St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 12-17-29

7-AGE. ....yrs. ....mos. 1 ....da 2

If LESS than 1 day. ....hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md (State or Country).

PARENTS.

10-NAME OF FATHER. Thomas E Tracy

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country).

12-MAIDEN NAME OF MOTHER. Ruth Seal Graden

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country).

14- (Informant) Mr Thomas Tracy

(Address) 451 Putnam Place

15- Filed ..... 193.. C. HAMPSON JONES, M. D. Registrar.

DEC 20 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 18/30

17- I HEREBY CERTIFY, That I attended deceased from January 18, 1930 to Jan 19, 1930

that I last saw h alive on January 18, 1930

and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Rickets

(Duration) ....yrs. 1 mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Adam D Wells M. D.

Jan 20, 1930 (Address) 836 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Joseph's Ceme as

DATE OF BURIAL. Jan 21, 1930

20-UNDERTAKER. Mary M Wiedefeld

ADDRESS 501 E 22nd St

instructions on back of certificates.

Spec.—5-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53172

90 E 53172

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 Llewellyn Ave ST., 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Heckman

(a) RESIDENCE NO. 2600 Llewellyn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Heckman

6 DATE OF BIRTH (month, day, and year) 7/20/1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	10	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Fred. Schuri

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Elz Schuri

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Louis Heckman

(Address) 2600 Llewellyn Ave

15 Filed 2-0 1930 19 C. HAMPSON JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 13 1930 to Jan 19 1930

(that I last saw h[illegible] alive on Jan 17 1930

and that death occurred, on the date stated above, at 8 00 A. m.

The CAUSE OF DEATH* was as follows:

Senility

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cardiac Calcification

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. H. Geyer M. D.

19 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Geo. D. Ruth

DATE OF BURIAL 1/21/30 19

20 UNDERTAKER Cedar Hill Cem-

ADDRESS 4235 Hartf[illegible]

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53173

CERTIFICATE OF DEATH

B 53173

1929
1897

1—PLACE OF DEATH

REGISTERED NO. 101

CITY OF BALTIMORE: (No. Provident Hosp ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vernon W. Holmes

(a) RESIDENCE NO. 218 2 Federal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	32	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Day

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) East Co. Va.

PARENTS

10 NAME OF FATHER William Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) East Co Va.

12 MAIDEN NAME OF MOTHER Alexander Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles Holmes

(Address) 2443 McCulloh St

15 Date received 2 0 1930, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1930, to Jan 30, 1930, that I last saw him alive on Jan 30, 1930 and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Frontal Gangrene

Acute Nephritis

Pneumonia (Lobar)

(duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Harris, M. D.

1/30, 1930 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem DATE OF BURIAL Jan 31, 1930

20 UNDERTAKER James E. Enright ADDRESS 1360 Kenyon

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

Dr. Kyle N. Folley 5103 Harford Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53174

E 53174

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6600 Hamptmett Ave (St.) 7-43 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Johie Michael Finn

(a) RESIDENCE NO. 6600 Hamptmett Ave (Hamilton) (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vala Adall

6 DATE OF BIRTH (month, day, and year) Jan 7th 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) R-R.

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Michael F. Finn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Vincent T. Finn

(Address) 6600 Hamptmett Ave

15 Filed 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Jan 19, 1930, that I last saw h[illegible] alive on Jan 19, 1930 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation (Rheumatic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Kyle N. Folley M. D.

19 (Address) 5103 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 1/22/1930

20 UNDERTAKER Wm Cook — ADDRESS 1173 St Paul St

Important. See instructions on back of certificate.

Stmp.—8-16-29—L. F. S.—100 Bks.

E 53175

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53175

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 322 S. Clinton St ST. No-2 WARD) Baltimore

2—FULL NAME John E Tyle

(a) RESIDENCE NO. 322 S Clinton St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara Tyle

6 DATE OF BIRTH (month, day, and year): May 25-1855

7 AGE: Years 74 | Months 7 | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:
(a) Trade, profession or particular kind of work: Bank Runner
(b) General nature of industry, business, or establishment in which employed (or employer): 486
(c) Name of employer: Bal W Trust Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS:
10 NAME OF FATHER: John E Tyle
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Clara Tyle
(Address) 322 S Clinton St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.
JAN 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19-1930

17 I HEREBY CERTIFY That I attended deceased from Dec 1, 1929, to Jan 19, 1930, that I last saw h[illegible] alive on Jan 18 1930 and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

I. Carcinoma Stomach (duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. V. Adler, M. D.

, 19 (Address) Crossville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Jan 15th 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53176

CERTIFICATE OF DEATH

Baltimore City Hospitals

101-001

E 53176

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 10-37 ST.) (WARD)

2—FULL NAME Andrew Hudak

(a) RESIDENCE NO. 55 S. Kresson ST. _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Wright

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Czecho-Slovakia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 2 0 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-19-30

17 I HEREBY CERTIFY, That I attended deceased from 1-14-30, 19..., to 1-19-30, 19...,

that I last saw him alive on 1-19-30, 19...

and that death occurred, on the date stated above, at 3 P.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 10 da.

CONTRIBUTORY (Secondary) _____ (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvey M. McLean, M. D.

1-20, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 1/23/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53172

E 53172

CERTIFICATE OF DEATH.

REGISTERED NO. 51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) 8-11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathleen Skipper

(a) RESIDENCE No. 2813 E. Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 21st 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Trappe Md

PARENTS

10 NAME OF FATHER Christopher C

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trappe Md

12 MAIDEN NAME OF MOTHER Bertha A Lauck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md

14 Informant Christopher C Skipper

(Address) 2813 E Chase St

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

JAN 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930. to Jan. 19, 1930.

that I last saw her alive on Jan. 19, 1930

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever with Carditis and Strepto. Viridans Septicaemia.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture.

(Signed) Lawrence Lena, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Jan 25th 1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 53178

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3200 Howard Park Ave ST., 25-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Reichenbecker

(a) RESIDENCE NO. 3200 Howard Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of: William Reichenbecker

6 DATE OF BIRTH (month, day, and year): Nov 23/1887

7 AGE: Years 42 Months 1 Days 27 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ellerslie Md.

PARENTS

10 NAME OF FATHER: George Wm Mock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Somerset Pa

12 MAIDEN NAME OF MOTHER: S. Etta Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant: Alice May Drummond

(Address) 125 E Crawford Ave Connellsville Pa

15 Filed . 19 . Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1930

17 I HEREBY CERTIFY That I attended deceased from Jan 20, 1930, to Jan 20, 1930, that I last saw h[illegible] alive on Jan 20, 1930, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hemiplegia

(duration) yrs. mos 4hrs

CONTRIBUTORY (Secondary): Hypertension

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) [illegible] M. D.

. 19 (Address) 921 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Cumberland Md

DATE OF BURIAL: May 22 1930

20 UNDERTAKER: Harry A Emmert & Son

ADDRESS: 104 Ridgewood Ave

TION is very important See instructions on back of certificates.

N 20 1930

Spec.—1-10-21—M&T—1500 Blks.

E 53179 HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 53179

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2634 E Baltimore St) 6-10 (WARD)

2-FULL NAME Mary Jaskulska

(a) RESIDENCE NO. 2634 E. Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Poland

PARENTS

10 NAME OF FATHER Maximilan Rynaszewski

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Daughter
(Address) 2634 E. Baltimore St.

15 JAN 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1929, to Jan 16, 1930.

that I last saw h alive on Jan. 12- 1930

and that death occurred, on the date stated above, at 1230 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B

(duration) abt 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical Exam of Sputum

(Signed) G. F. Cox, M. D.

Jan 19, 1930 (Address) 24 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Jan 21 1930

20 UNDERTAKER John M Weber & Old — ADDRESS Chester

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Lertola

HEALTH DEPARTMENT—CITY OF BALTIMORE

67-001

E 53180

CERTIFICATE OF DEATH

E 53180

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1141 Hanover St. St. 23-33 Ward)

2-FULL NAME Joseph Lertola.

(a) RESIDENCE NO. 1004 Light St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ds. How long in U. S., if of foreign birth? 40 da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stone cutter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Italy.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy.

14 Informant Andrew Serra.
(Address) 1013 S. Sharp St.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning.
Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

1/20. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Jan 21 1930
20 UNDERTAKER Wendell J Dippel	ADDRESS 300 S Ed

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53181

E 53181

CERTIFICATE OF DEATH

REGISTERED NO. ✓ 71-09 2

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 4-30 ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Funk

(a) RESIDENCE NO. Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ✓ ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Virginia Funk

6 DATE OF BIRTH (month, day, and year) July 18 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Upholsterer 066

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sallie Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Elsie Funk

(Address) Frederick Ave

15 2 0 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 —, 1930, to January 20, 1930, that I last saw h alive on January 20 —, 1930 and that death occurred, on the date stated above, at 12:40 P m.

The CAUSE OF DEATH* was as follows:

Meningitis - cerebro spinal.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 17-1930 (Removal of nasal polyp)

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and symptoms

(Signed) C. W. Peahe M. D.

1/20, 1934 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Frederick Ave	Jan 23 1930
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 Park Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53182

99-301

E 53182

CERTIFICATE OF DEATH

REGISTERED NO. 13-53

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4602 Schenley Road ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.) WARD

2—FULL NAME Rachel T. Harle

(a) RESIDENCE NO. 4602 Schenley Road ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Valentine Hare

6 DATE OF BIRTH (month, day, and year) Feb. 15-1848.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER William Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Steiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Valentine Hare

(Address) 4602 Schenley Road

15 Filed JAN 20 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19-1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1928, to Jan. 19, 1930, that I last saw h alive on Jan - 18, 1930 and that death occurred, on the date stated above, at 10:20 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis-
Pt. Cosmer Dx Pneumonia.
Fracture of Leg 1928 - with Recurrence

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Fracture of Neck of Femur. Senile Arteriosclerosis (duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. Gibson Taylor, M. D.

1/20. 1930 (Address) 4822 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Jan. 21 1930.

20 UNDERTAKER Horace F. Burgee

ADDRESS 363 Falls Road

Important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53183

CERTIFICATE OF DEATH

118-002 E 53183

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E. Fitzinger

(a) RESIDENCE NO. 3628 Falls Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 0 mos. 20 da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. C. E. Fitzinger

6 DATE OF BIRTH (month, day, and year) Dec. 31, 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	62	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Richard Fitzinger

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balt. Co.

12 MAIDEN NAME OF MOTHER Eliza Fansing

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Hospital Record

(Address)

DEC 20 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 1. 20. 1930

17 I HEREBY CERTIFY, That I attended deceased from 1. 18. 30 to 1/20/30, 19..., that I last saw h... alive on 1/20/30, 19..., and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction (Abdominal adhesions following appendectomy 1 day) (duration) ... yrs. ... mos. 3 da.

CONTRIBUTORY (Secondary) Pulmonary edema with acute dilatation (duration) ... yrs. ... mos. 1 ... da.?

18 Where was disease contracted? Home

If not at place of death?

Did an operation precede death? Yes Date of 1-19-30

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) ... M. D.

(Address)

*State (1) Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (3) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

Date of Burial Jan. 24 1930

20 UNDERTAKER Horace F. Burgee

ADDRESS 3631 Falls Road

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53184

CERTIFICATE OF DEATH

89 ✓

E 53184

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 4207 Underwood St. WARD) 27-49

2—FULL NAME Stanley Meade Reynolds.

(a) RESIDENCE NO. 4207 Underwood St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Appleyard Reynolds

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst. Editor

(b) General nature of industry, business, or establishment in which employed (or employer) The Sun

(c) Name of employer Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Dr. Geo. B. Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ada C. Hicke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D.C.

14 Informant Mrs. Wm Caulk (Address) 227 W. Lanvale St.

15 Filed JAN 21 1930 C. HAYDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 6. 1929. to Jan 19. 1930

that I last saw h alive on Jan 19 1930

and that death occurred, on the date stated above, at 11a m.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. W. Watson, M. D.

, 19 (Address) 817 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Jan. 21 1930

20 UNDERTAKER Wm Tuckner Sons ADDRESS North Ave

Important: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53185

CERTIFICATE OF DEATH

E 53185

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) Colby Hospital St., 11-7 Ward)

2-FULL NAME Shelby Dyer

(a) RESIDENCE NO. 570 N Calvert St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M | 4 Color or Race: W | 5 Single, Married, Widowed or Divorced, (write the word): S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 30 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Dry Goods
(c) Name of employer

9 BIRTHPLACE (city or town): City
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Hosp. Records
(Address)

15 Filed JAN 21 1930 HAMILTON JONES, M. D. Registrar
By Reg.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:*
Lobar Pneumonia
(Duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) H. G. Radcliffe M. D.
, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer
DATE OF BURIAL: 1/24/1930

20 UNDERTAKER: J. A. Moran
ADDRESS 300 E. Baltimore

IMPORTANT: Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53186

CERTIFICATE OF DEATH.

5 E 53186

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital ST. WARD)

2-FULL NAME Mrs. George H. Herbert

(a) RESIDENCE NO. 2729 Eastern Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 1 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Richter

6 DATE OF BIRTH (month, day, and year) Dec 14 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	57	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Shipcarpenter

(c) Name of employer Pennsylvania R.R. Co Baltimore

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katie Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Martha Herbert

(Address) 2729 Eastern ave

15 Filed JAN 21 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1930, to Jan. 19, 1930,

that I last saw h alive on Jan. 19, 1930

and that death occurred, on the date stated above, at 10 p. m

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

Chronic glomerulo-nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Laboratory

(Signed) D. K. Klein, M. D.

, 19 (Address) Wertheim Bld'g

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cat Cairn

DATE OF BURIAL 1/23/1930

20 UNDERTAKER Geo. Peter & Son 2503 Edmondson Ave

ADDRESS

CAUSE OF DEATH must be plainly written, and all items of certificates. See instructions on back of certificates. TION is very important

Spec.—2-29-28—L. F. S.—500 Blks.

E 53187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 53187

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3347 Belair Road ST., 46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Virtue Sharples

(a) RESIDENCE NO. 3347 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: Eaton Sharples

6 DATE OF BIRTH (month, day, and year): Sept 6th 1871

7 AGE: Years 58 | Months 4 | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa

PARENTS

10 NAME OF FATHER: Charles Howard Virtue

11 BIRTHPLACE OF FATHER (city or town) (State or country): /

12 MAIDEN NAME OF MOTHER: Sarah Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Jersey

14 Informant: Eaton Sharples

(Address) 3347 Belair Road

15 Filed JAN 21 1930 By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1928 to Jan 18 1930.

that I last saw he alive on Jan 17 1930

and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) E. Howard Fonolla M. D.

19 (Address) 817 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Garrwood Cemetery

DATE OF BURIAL: 1/21/1930

20 UNDERTAKER: Geo. Weber & Son

ADDRESS: 2503 Edmondson

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53188

CERTIFICATE OF DEATH

90 E 53188

1—PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lydia Bacon

(a) RESIDENCE NO. 228 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
81 unknown	?80 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Abraham Pinkney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-19-30

17 I HEREBY CERTIFY, That I attended deceased from 12-30-29, 19..., to 1-19-30, 19..., that I last saw her alive on 1-19-30, 19..., and that death occurred, on the date stated above, at 6:35 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

over 21 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

over 21 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren M. McLean, M. D.

1-20, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Jan 21 1930

20 UNDERTAKER H. & B. Brown's Son

ADDRESS 108 N. Monty

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53189

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 53189

22-31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Pollard

(a) RESIDENCE NO. 108 W. Montgomery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ? (State or country) Va.

PARENTS

10 NAME OF FATHER Willis Pollard

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Va.

12 MAIDEN NAME OF MOTHER Rebecca Morse

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Va.

14 Informant Records of

(Address)

15 Filed JAN 27 1930, 19 C. HAMPSON JONES, M. D. Registrar

Per L.A.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-30

17

I HEREBY CERTIFY, That I attended deceased from 1-2, 1930, to 1-18, 1930,

that I last saw him alive on 1-18, 1930

and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

over

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvey W. McLean, M. D.

1-18, 1930 Address Balto. City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion	Jan 2 1930
20 UNDERTAKER	ADDRESS
S. A. Brown's Son	108 W. Monty

Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53190

E 53190

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 227 N. Montford ave ST. 6 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Chase

(a) RESIDENCE. No. 227 N. Montford ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Annie Hammond

(Address) 227 N. Montford ave

15 Filed JAN 21 1930 19 R.H.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1930, to Jan 18, 1930,

that I last saw him alive on Jan 18, 1930,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension
Cerebral Apoplexy
(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. G. Grewal M. D.

, 19 (Address) 156 N. Milton Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury cemetery	Jan 22 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53191

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 37 So Ellwood Ave Ward 1-7)

Registered No. 1601 E 53191

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Farias

(a) Residence No. 37 So Ellwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jany 20/30

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 5 hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9-BIRTHPLACE (city or town) Baltimore Md (State or Country),

PARENTS.

10-NAME OF FATHER Leo Farias (Philip)

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country),

12-MAIDEN NAME OF MOTHER Rachel M. Farias

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country),

14- (Informant) Rachel M. Farias

(Address) 37 So Ellwood Ave

15- (Filed) JAN 21 1930 C. HAMPSON JAMES, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jany 20/30

17- I HEREBY CERTIFY, That I attended deceased from Jany 20, 1930, to Jany 20, 1930, that I last saw h[illegible] alive on Jany 20, 1930, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth (5 Mo.)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson James M. D.

1/30, 1930 (Address) 330 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, UNIVERSITY OF MARYLAND, 10....

DATE OF BURIAL, JAN 20 1930

20-UNDERTAKER, Comm'r Health

ADDRESS

Instructions on back of certificates.

Inserting Name of Father Records May 8 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53192

CERTIFICATE OF DEATH

90 E 53192

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ST. 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abe Robinson

(a) RESIDENCE NO. 1118 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? —yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
Est 51 & 59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?

(State or country) Va.

PARENTS

10 NAME OF FATHER Alex. Robinson

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Va.

12 MAIDEN NAME OF MOTHER Eliz. Davis

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Va.

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed JAN 21 1930 Registrar HAMPSON JONES, M. D.

4284

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-15-30

17

I HEREBY CERTIFY, That I attended deceased from 7-25, 1929, to 1-15, 1930,

that I last saw him alive on 1-15, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchiectasis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X-ray

(Signed) Marion W. McLean, M. D.

1-16, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JAN 20 1930

Per. Mrs. M. WOODALL

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53193

CERTIFICATE OF DEATH

3/ E 53193

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO.

CITY OF BALTIMORE: (No. 16-24 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Robinson

(a) RESIDENCE NO. 1217 Parrish st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Robinson

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
37	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Jacob Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address) UNIVERSITY OF MARYLAND

15 Filed JAN 21 1930 H. [illegible] M. (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16, 19 29, to Jan. 16, 19 30, that I last saw him alive on Jan. 16, 19 30 and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

1-16, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER D.

ADDRESS

JAN 20 1930

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1/2 E 53194

1—PLACE OF DEATH Baltimore City Hospitals (The) REGISTERED NO.

CITY OF BALTIMORE: (No. 4-26 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Donovan

(a) RESIDENCE NO. 712 W. Lexington st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER James Donovan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Hospital Records

(Address)

15 Filed 1930 4286 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1929, to Jan. 17, 1930, that I last saw him alive on Jan. 17, 1930 and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Donovan Jr. M. D.

1-17-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

JAN 20 1930

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53195

CERTIFICATE OF DEATH

E 53195

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 315 N. Greene St. (Ward) 4-25

2-FULL NAME Peter Simon

(a) RESIDENCE NO. 315 N. Greene St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Greece

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Peter Simon
(Address) 315 N. Greene St.

15 Filed 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Poisoned by Carbon Monoxide (Illuminating Gas)
Suicide
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

July 16 1930 (Address) 2736 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Crem — DATE OF BURIAL 7/21 1930

20 UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun & Hollins

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 53196

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 53196

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4104 Maine St. 15-64 Ward)

2-FULL NAME Adrian Hughes

(a) RESIDENCE NO. 4104 Maine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hughes

6 DATE OF BIRTH (month, day, and year) July 24 - 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	64 65	5	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lawyer 042
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country) "

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country) "

12 MAIDEN NAME OF MOTHER Mary Conley

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country) "

14 Informant Mrs Hughes
(Address) 4104 Maine Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Lusk, M. D.

Jan 14 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 1/22 1930

20 UNDERTAKER Robert Brooks Son — ADDRESS Baltimore Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53197

CERTIFICATE OF DEATH

E 53197

REGISTERED NO. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating at Pier 19

City of Baltimore: (No. Light St. Wharf. St. 19-27 Ward)

2-FULL NAME Charles Thomas.(C)

(a) RESIDENCE NO. 831 N. Bruce St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Do not know.
(State or country)

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Do not know.

14 Informant: Police Report. S.D.
(Address)

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Found January 15, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Probably accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Eisenhardt M. D.

1/30. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U. S. National Cem — DATE OF BURIAL: 1/21st 1930

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun Hollins st

NOTE—Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS MUST STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53198

CERTIFICATE OF DEATH

90

E 53198
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. 290 Lanvale St., 3-4 Ward)

2-FULL NAME Vida Harvey

(a) RESIDENCE NO. 290 Lanvale St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Edward Harvey

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) 870
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Somerset County

PARENTS

10 NAME OF FATHER Mathiel Hodges

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Somerset County

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Somerset County

14 Informant Clarence Harvey
(Address) 290 N. Carlton St.

15 Filed Jan 22 19 30 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis
(duration) yrs. 1 mos. / ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death? —
Did operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Clinical

(Signed) C. E. Glades, M. D.
(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eastern Cemetery	Jan 22 1930
20 UNDERTAKER Wendel & Hospital	ADDRESS Baltimore

Must be carefully supplied. AGE should be stated EXACTLY. DISEASES causing DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53199

CERTIFICATE OF DEATH.

90 ✓

E 53199

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Ward

2-FULL NAME David L Chilcoat.

(a) RESIDENCE NO. 3544 Buena Vista ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): April 14, 1909.

7 AGE: 20 Years 9 Months 4 Days. If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): md

(State or country)

PARENTS

10 NAME OF FATHER: David E. Chilcoat

11 BIRTHPLACE OF FATHER (city or town): md

(State or country)

12 MAIDEN NAME OF MOTHER: Elsie Spurrier

13 BIRTHPLACE OF MOTHER (city or town): md

(State or country)

14 Informant: David E. Chilcoat

(Address) 3544 Buena Vista ave

15 Filed JAN 21 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and from the autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

18 CAUSE OF DEATH* was as follows: Coronary Thrombosis of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Mossner M. D.

(Coroner)

1/19 1930 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn. Date of Burial: Jan 21 1930

20 UNDERTAKER: Chenowith Son ADDRESS 3605 Clifton ave

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53200

CERTIFICATE OF DEATH

129

E 53200

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 542 Lanford ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura A Garrison

(a) RESIDENCE NO. 542 Lanford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wife Geo. Garrison

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: Years 64; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gen. Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Geo. Heath

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Laura Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Norma Vincent

(Address) 542 Lanford

JAN 1 1930

[illegible] M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/19/1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1930, to Jan. 19, 1930, that I last saw h[illegible] alive on Jan 18, 1930 and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Uremia

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) about 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Thompson M. D.

1/20 1930 (Address) 1012 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 1-21 1930

20 UNDERTAKER: Byron Wright

ADDRESS: 1218 McElderry St.

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53201

CERTIFICATE OF DEATH

90 ✓

REGISTERED NO. E 53201

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST. 26-32 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Moses Smith

(a) RESIDENCE NO. 320 N. 13th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ?yrs. ? mos. ?ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Virginia Smith

6 DATE OF BIRTH (month, day, and year) June 28, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65 ?	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 0-73

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Crown Oil & Wax Co.

9 BIRTHPLACE (city or town) Baltimore County (State or country) Md.

PARENTS

10 NAME OF FATHER Mullen C. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address Balto. City Hospitals

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-20-30

17 I HEREBY CERTIFY, That I attended deceased from 12-30-29, 19..., to 1-20-30, 19..., that I last saw him alive on 1-20-30, 19..., and that death occurred, on the date stated above, at 5:40 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) ... yrs. 14 mos. ... da.

CONTRIBUTORY (Secondary) Arteriosclerosis Hypertension

(duration) ... yrs. 6 mos. ... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marion W. McLean, M. D.

1-20, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Jan. 28, 1930

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore St & Broadway.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53202

E 53202

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 56-1

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Reich

(a) RESIDENCE NO. 3304 Schuck ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced RUSBAND of (or) WIFE of Louis Reich

6 DATE OF BIRTH (month, day, and year) Sept 22. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75 ?	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) Germany

PARENTS

10 NAME OF FATHER ? Schuster

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Records (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-30

17 I HEREBY CERTIFY, That I attended deceased from 1-15, 1930, to 1-18, 1930, that I last saw her alive on 1-18, 1930 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Hypertension over 4 (duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin W. McLean, M. D.

1-19, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Jan. 21. 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St & Boundary

JAN 21 1930 BALTIMORE CITY HOSPITALS, M.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. P. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53203

CERTIFICATE OF DEATH

90 E 53203

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2630 E Monument ST. 7-17 WARD)

2—FULL NAME Catherine B. Daniels

(a) RESIDENCE NO. 2630 E. Monument ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 60 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of George. W. Daniels

6 DATE OF BIRTH (month, day, and year) aug 24-1833

7 AGE	Years	Months	Days 24	If LESS than 1 day, hrs. or min.
	96	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home. do

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Ferguson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) not Known

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not Known

14 Informant Mrs. Anna Garrett

(Address) 2630 E. Monument St

15 Filed JAN 21 1930 BALTIMORE, MD. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18-1930

17 I HEREBY CERTIFY That I attended deceased from December 19 29 to Jany 18 19 30

that I last saw h Er alive on Jany 18 19 30

and that death occurred, on the date stated above, at 10 25 p.m.

The CAUSE OF DEATH was as follows:

Infirmities of advanced age

(duration) yrs. mos. ds.

Sudden Heart failure

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Walter A. Mey M. D.

Jan 20. 19 30 Address 1032 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Jan 21 19 30

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St

Important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53204

E 53204

CERTIFICATE OF DEATH.

89

REGISTERED NO. 30-71

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4017 Walrad Ave. ST. WARD.

2-FULL NAME Carl Petersen.

(a) RESIDENCE. No. 4017 Walrad Ave. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Camilla Petersen

6 DATE OF BIRTH (month, day, and year) June 25th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6	25 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) Lunch Room

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denmark.

PARENTS

10 NAME OF FATHER Peter Petersen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant (Address) Mrs. Camilla Petersen. 4017 Walrad Ave.

15 Filed JAN 21 1930 19 C. HAMPTON MOORE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19- 1930

17 I HEREBY CERTIFY, That I attended deceased from in summer 1927 to 1928 for heart trouble that I last saw h[illegible] alive on January 19 19 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Angina pectoris. Heart after death instructed by Coroner Blades to sign certificate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. R. Leider, M. D.

1/20, 1930 (Address) 3421 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ceder Hill Cemetery

DATE OF BURIAL: Jan. 22, 1930

20 UNDERTAKER: George L. Schwab

ADDRESS: 2101 Fredk. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 ✓ E 53205

E 53205

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 Wilhelm St. 70-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Trost.

(a) RESIDENCE. NO. 2112 Wilhelm St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Trost.

6 DATE OF BIRTH (month, day, and year) Jan. 16th. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	-----	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work . Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John W. Trost.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Hesse.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) America.

14 Informant (Address) Mrs. Mary Trost. 2112 Wilhelm St.

15 Filed JAN 21 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1930, to Jan 18, 1930

that I last saw h alive on Jan 10, 1930

and that death occurred, on the date stated above, at 9:50 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
(Apoplexy)

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Fernando E. Richards, M. D.

, 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Jan 21th 1930
20 UNDERTAKER George L. Schwab	ADDRESS 2101 Frederick Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 53206 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53206

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Orleans St.) (WARD) 10 & 7

REGISTERED NO. 1601

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Ringling

(a) RESIDENCE NO. Hampstead ST. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): 1-20-30

7 AGE: Years — Months — Days

If LESS than 1 day 5 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Premature Child

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (City or town) (State or country): St Joseph Hospital Baltimore Md.

PARENTS

10 NAME OF FATHER: Vernon Ringling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cranberry Md.

12 MAIDEN NAME OF MOTHER: Mildred Quigley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West minster Md

14 Informant (Address): Hospital Records

15 Filed JAN 21 1930

C. ARTHUR GRIMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-20-30, 19 , to 1-20-30, 19 ,

that I last saw h live on 1-20-30, 19 ,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Premature (7 months)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. 5 days

18 Where was disease contracted if not at place of death? Ham

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H B Hunting, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leisters Church Carroll Co.

DATE OF BURIAL: 1/21 1930

20 UNDERTAKER: Edw C Tipton

ADDRESS: Hampstead Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53207

CERTIFICATE OF DEATH

91-902

E 53207

REGISTERED NO. 10-14

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily Haslam

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 16 March 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel Haslam

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Hagenfrig

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley St.

15 Filed JAN 2 1930, 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/5/30, 19..., to 1/18, 1930, that I last saw h... alive on 1/17, 1930, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Senility
Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Dyspepsia (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Dr Bosworth, M. D.

1/20, 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet — DATE OF BURIAL Jan. 21 1930

20 UNDERTAKER William J. Schaefer — ADDRESS 1816 Monument

Important. See instructions on back of certificate.

JAN 21 1930 [illegible]

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 53208 — 31 E 53208

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. 3-5 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alvin Mears

(a) RESIDENCE NO. 103 Broad Alley ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marcie Mears

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Louis Mears

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lucinda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of

(Address): Balto. City Hospitals

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-18-30

17 I HEREBY CERTIFY, That I attended deceased from 1-14-30, 19..., to 1-18-30, 19...,

that I last saw him alive on 1-18-30, 19...

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Miliary

Tbc. of Lungs

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): 10 days: Tbc. Meningitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? X-ray: Miliary Stain

(Signed) Warren W. McLean, M. D.

1-20. 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	June 22, 1930
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1725 Eastlake

Important. See instructions on back of certificates.

JAN 21 1930 H. M. JONES M. Registrar

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

53209 38 E 53209

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 16-22 Ward)

2-FULL NAME ~~Thomas~~ Green (Lena)

(a) RESIDENCE NO. 1008 Whatcoat St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos

6 DATE OF BIRTH (month, day, and year): Jan 15-1884

7 AGE: Years 46 | Months | Days 3 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 031
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Leigh Green

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Annie Hall

13 BIRTHPLACE OF MOTHER (city or town): Md.
(State or country)

14 Informant: Sarah Jones
(Address): 1323 W Lanvale

15 Filed JAN 21 1930 HAMILTON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or ~~inquiry~~) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Aneurism of Aorta

(duration) Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam

(Signed) H. Feldstein, M. D.

Jan 18 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Jan 24, 1930

20 UNDERTAKER: Mrs. A. A. Elliott — ADDRESS: 1725 Ashland Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53210

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 53210

CERTIFICATE OF DEATH

REGISTERED NO. 18-11a

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 N. Fremont ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Foster Hill

(a) RESIDENCE NO. 404 N. Fremont ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	col	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Lilian Hill

6 DATE OF BIRTH (month, day, and year) — 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Streator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jas. Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lilian Hill

(Address) 404 N. Fremont ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 17 30

17 I HEREBY CERTIFY, That I attended deceased from Jany 11, 1930, to Jany 17, 1930

that I last saw him alive on Jany 16, 1930

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) David Wagner M. D.

Jan 21, 1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Jan. 24, 1930

20 UNDERTAKER Mrs. Katie C. Phillips

ADDRESS 322 Schroeder st

Important: See instructions on back of certificate.

Spec.—3-10-21—M&T—1500 Bks.

E 53211. HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

90 E 53211

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.) St Agnes Hospital ST. 90-10 (WARD)

2-FULL NAME James Derwart

(a) RESIDENCE NO. 14 N. Morley St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Derwart

6 DATE OF BIRTH (month, day, and year) July 8 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	35 ~~1894~~	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pike fitter

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Jno. Derwart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mc Kennedy,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Minnie Derwart

(Address) 14 N. Morley St City

15 Filed JAN 21 1930 HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-19- 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-3- 1930, to 1-19 1930,

that I last saw him alive on 1-19 1930,

and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 1/22/1930

20 UNDERTAKER Robt. J. Turner

ADDRESS 1442 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53212

CERTIFICATE OF DEATH

74-001

E 53212

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 14-28 Ward)

2-FULL NAME Ford Kerbe

(a) RESIDENCE NO. 1837 Door St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Miller

6 DATE OF BIRTH (month, day, and year) Do not Know

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
Abt.	68	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truckster
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Kerbe

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Ketchner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Wellington Kerbe
(Address) 439 S. Ainsworth St

15 Filed ..., 19... Registrar

NOV 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

6 Days (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of

Was there an autopsy?

What confirmed diagnosis?

Nov 30

(Signed) H. C. Thistle, M. D.

19 (Address) 1438 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 11/21 1930

20 UNDERTAKER G. G. Zoller & Sons

ADDRESS 1318 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53213

21 E 53213

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1436 Henry ST. 24-33 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary S. Freburger

(a) RESIDENCE NO. 1436 Henry ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 9. 1929

7 AGE: Years — Months: 5 — Days: 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Robert E. L. Freburger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. md

12 MAIDEN NAME OF MOTHER: Catherine A. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. md

14 Informant: Robert Freburger

(Address) 1436 Henry St

15 [illegible] JAN 21 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 20, 1930, that I last saw her alive on Jan. 20, 1930, and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Erysipelas (duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

1/20, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Jan 21 1930

20 UNDERTAKER: Margaret B. Flynn

ADDRESS: 1422 Light St.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

53214

25-75 100-001

E 53214

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 102 Pontiac Ave. St., Ward)

2-FULL NAME Doris May Dehn.

(a) RESIDENCE NO. 102 Pontiac Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) June 5, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Albert Dehn.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Lillian Johnson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Lillian Dehn. (mother)
(Address) 102 Pontiac Ave.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia
unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Albert Heimanek M. D.
1/20, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross C. C. Co

DATE OF BURIAL Jan. 21, 1930

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1425 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 21 1930

Spec.—1-10-21—M&T—1500 Blks.

E 53215

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53215

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. 9-17 WARD)

2-FULL NAME Mrs. Effie Burke.

(a) RESIDENCE NO. Benson, Maryland ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus Burke. Unknown.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Augustus Burke (Address) Benson Md

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-20 1930.

17 I HEREBY CERTIFY, That I attended deceased from 1-16 — 1930 to 1-20 — 1930.

that I last saw her alive on 1-20 — 1930.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Gastritis ulcer ?

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Hematemesis

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Cundiff, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenkeen Lutheran Cem

DATE OF BURIAL Jan 22 1930

20 UNDERTAKER Hornberger & Goods

ADDRESS Benson

FEB 1 1930 C. HARRISON JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—S.&T.—500 Bks.

E 53216

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 53216

CERTIFICATE OF DEATH.

27-53 164

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 103 Ridgewood Road ST. (WARD)

2-FULL NAME Rachel Ann Slagle

(a) RESIDENCE NO. 103 Ridgewood Road ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles W. Slagle

6 DATE OF BIRTH (month, day, and year) October 7-1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	90	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER Benj Matthews

11 BIRTHPLACE OF FATHER (city or town) ? ? (State or country) Maryland

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) ? ? (State or country) Don't Know

14 Informant Mrs. Charles W. Slagle
(Address) 103 Ridgewood Road.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1912, to Jan 20, 1930
that I last saw her alive on Jan 20, 1930
and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Intestinal Colic, Exhaustion

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Senile

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. C. Kelly M. D.

Jan. 19 30 (Address) 6 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Jan 22 1930

20 UNDERTAKER Stewart & Mowen Company ADDRESS 108 W. Saratoga St.

JAN 21 1930

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53217

CERTIFICATE OF DEATH

1-001

E 53217

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 301 N. Grmur St. 4-25 Ward)

2-FULL NAME Mrs. Lydia Fritz

(a) RESIDENCE NO. 301 N. Grmur St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Fritz

6 DATE OF BIRTH (month, day, and year) about 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52 51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Florence White
(Address) 536 N Brice St

15 Filed, 19, Registrar

JAN 21 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Poisoned by Carbon Monoxide Illuminating Gas. Probably Accidental - due to temporary insanity. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Gilbert, M. D.

1/20. 1930. (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk	Jan 21 1930
20 UNDERTAKER Harry A. Fritzke, 410	ADDRESS Edmondson Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

CERTIFICATE OF DEATH

E 53218

E 53218

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 23 W. West ST. 2321 (WARD)

2—FULL NAME Frank Holzum

(a) RESIDENCE NO. 23 W. West ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? 42 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Barbara Holzum

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bulldozer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Cumbria

PARENTS

10 NAME OF FATHER Joseph Holzum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumbria

12 MAIDEN NAME OF MOTHER Mc Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumbria

14 Informant Joseph Holzum

(Address) 23 W. West St

15 Filed JAN 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 20, 1930, that I last saw him alive on Jan 20, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Acute Bronchopneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Curtis Bay,

Did an operation precede death? No, Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination,

(Signed) A Lane, M. D.

, 19 (Address) 1215 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Jan 23. 1930

ADDRESS, Ashland Ave

20 UNDERTAKER Frank Brackson 1906

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53219

CERTIFICATE OF DEATH.

90 E 53219

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 N. Caroline St 10-9 WARD)

2-FULL NAME Annie W. Green

(a) RESIDENCE NO. 608 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Green

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER J. Westly Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Dockins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm. H. Green (Address) 608 N. Caroline St.

15 Filed JAN 21 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1929, to Jan 18, 1930,

that I last saw h alive on Jan 17, 1930,

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency and hypostatic pneumonia

(duration) yrs. 1 mos da.

CONTRIBUTORY (Secondary) Pleurisy; also pulmonary Hemorrhage in abdominal probably Abdominal aortic aneurysm (duration) yrs. mos. d.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. F. Young M. D.

1/19, 1930 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery DATE OF BURIAL Jan 22 1930

20 UNDERTAKER Chas. N. Johnson & Co. ADDRESS Caroline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-28—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53220

CERTIFICATE OF DEATH.

45 E 53220

E 53220

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 423 W. Winston Ave St. 47-48 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Theresa L. Judge

(a) RESIDENCE No. 423 W. Winston Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Edward Samuel Judge

6 DATE OF BIRTH (month, day, and year): April 1, 1852

7 AGE: 77 Years 78 Months 9 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa

PARENTS

10 NAME OF FATHER: James F. Leahy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Philadelphia Pa

12 MAIDEN NAME OF MOTHER: Rebecca Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila. Pa.

14 Informant (Address): Mrs F. L. Snyder

15 Filed JAN 21 1930 C. HAMPSON JONES, M. D. Registrar

Per NKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929, to Jan 19, 1930, that I last saw her alive on Jan 19, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of descending Colon

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary): Respiratory failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-rays

(Signed) W. Raymond Peters, M. D.

19 (Address) 1908 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 1/22 1930

20 UNDERTAKER: Chas P. Saunders

ADDRESS: 1810 Druid Hill Ave

TION is very important See instructions on back of certificates.

Spec.—2-29-25—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53221

CERTIFICATE OF DEATH

88 E 53221

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 620 E Wyandotte ST., (WARD) dec 47

2—FULL NAME John P. Foley

(a) RESIDENCE NO. 620 E. Wyandotte ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhemena Foley

6 DATE OF BIRTH (month, day, and year) Nov. 11-1860

7 AGE Years 69 Months 2 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer) Penn RR 67

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Dennis E. Foley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Gillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. A. Foley

(Address) 620 E Wyandotte

15 Filed JAN 21 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 19, 1930, that I last saw h.i.a. alive on Jan 16, 1930, and that death occurred, on the date stated above, at 4 05 A.M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 1 day

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Johnston, M. D.

, 19 (Address) 4305 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Jan 22 1930

20 UNDERTAKER D. John A. Moran

ADDRESS 3000 E. Baltimore

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53222

CERTIFICATE OF DEATH

111-001 E 53222

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Burns

(a) RESIDENCE NO. 2716 Philadelphia Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

Important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asbestos Work o/o

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Tom Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES M.D.

JAN 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-20-30

17 I HEREBY CERTIFY, That I attended deceased from 1-15, 1930, to 1-20, 1930, that I last saw him alive on 1-20, 1930 and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Ruptured ulcer, paralytic ileus (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 1-15-30

Was there an autopsy? yes

What test confirmed diagnosis? Operation & autopsy

(Signed) L. U. Lumpkins, M. D.

1-20, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ash Lawn Cem	1/23/1930
20 UNDERTAKER J. A. Moran	ADDRESS 309 E. Balto.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53223 — 120-001 — E 53223

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2510 E. Strathmore Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine E. Burns

(a) RESIDENCE NO. 2510 E. Strathmore Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year): Dec 6 1862

7 AGE — Years: 67 — Months: 1 — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Symons

(Address) 2510 E. Strathmore Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan 19, 1930, that I last saw her alive on Jan 19, 1930, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Herman A Yost, M. D.

19 (Address) 5106 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 1/22/1930

20 UNDERTAKER: J. A. Moran

ADDRESS 3900 E. Baltimore

Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 53224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53224

Registered No. 161

1-PLACE OF DEATH

City of BALTIMORE: (No. 7290 Franklin St. 17-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Ferguson

(a) Residence No. ..... St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	Single

5a-If married, widowed, or divorced
HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1-19-'30

7-AGE. ..... yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9-BIRTHPLACE (city or town) Balto, Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Kelly Ferguson

11-BIRTHPLACE OF FATHER (city or town) Lunenburg
(State or Country), Va.

12-MAIDEN NAME OF MOTHER, Sadie Vaughn

13-BIRTHPLACE OF MOTHER (city or town) Lunenburg Va
(State or Country),

14- (Informant) .....
(Address) .....

15- Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar.

4289

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 20 - 1930

17- I HEREBY CERTIFY, That I attended deceased from Jan 19 1930 to Jan 20 1930
that I last saw h[illegible] alive on Jan 19 1930
and that death occurred, on the date stated above, at 11 A m.
The CAUSE OF DEATH* was as follows:

I Prematurity (37 wks)

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

1930 (Address) [illegible]

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL, ... 19....

20-UNDERTAKER, [illegible] Commissioner Health — ADDRESS JAN 21 1930

FEB 2 1930

instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 53225 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53225

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 206 Hawthorn Rd ST. 27-53 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Stolpp

(a) RESIDENCE NO. 206 Hawthorn Rd. ST., Roland Park WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 29. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Stolpp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William S. Stolpp (Address) 206 Hawthorn Rd

15 Filed JAN 21 1930, 19 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/19/1930

17 I HEREBY CERTIFY, That I attended deceased from 1/3, 1930, to 1/19, 1930, that I last saw him alive on 1/19, 1930, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

General arterio-sclerosis

(probably years -)

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Bronchi-Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? General Physical

(Signed) W S Love, M. D.

1/20, 1930 (Address) 836 W. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL Jan 22 1930

20 UNDERTAKER George J Smith

ADDRESS 437 L Pollin

CAUSE OF DEATH must be plainly written, so that it may be properly classified. EXACT STATEMENT OF CAUSE IS very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53226

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53226

38

CERTIFICATE OF DEATH

REGISTERED NO. 3-59

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ST. WARD)

2—FULL NAME John Thomas Farden

(a) RESIDENCE NO. 2442 Druid Hill Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. da. How long in U. S., if foreign birth? — yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Oct 22, 1870 ~~1-18-30~~ ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59 ?	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jos. B. Farden

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Buck Susan E White

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed 2 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-18-30

17 I HEREBY CERTIFY, That I attended deceased from 10-24, 1929, to 1-18, 1930, that I last saw him alive on 1-18, 1930 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. da.

18 Where was disease contrarted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin H. McLean, M. D.

1-19, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Jan 22, 30

20 UNDERTAKER John M Johnson

ADDRESS 2325 Madison Ave.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53227

CERTIFICATE OF DEATH

31

E 53227

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 520 Jasper St. 7-25 (Ward)

2-FULL NAME Geo W. Medley

(a) RESIDENCE NO. 520 Jasper St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No.

6 DATE OF BIRTH (month, day, and year): Jan 3-1885

7 AGE: Years 45 Months - Days 16 IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Driver 023
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Geo Medley

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Emma Butler

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Jessie Tibbs
(Address): 320 Jasper

15 Filed ... C. HAMPSON JONES, M. D. Registrar
By ...

12 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) ...yrs. 6 mos. ...da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Polk Smith, M. D.
(Address) Jan 24 1930 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	1-27-1930
20 UNDERTAKER	ADDRESS
Daniel Conlon	96

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 53228

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53228

CERTIFICATE OF DEATH.

131

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver Sts.) (7-5 WARD)

2-FULL NAME Mary Vicchio

(a) RESIDENCE No. 2229 Huntingdon Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: John Vicchio

6 DATE OF BIRTH (month, day, and year): Mar 1878

7 AGE — Years: 51 — Months: 10 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Richard DeLoia

11 BIRTHPLACE OF FATHER (City or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Leonia DeLoia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): John Vicchio 2229 Huntingdon Ave

15 Filed: JAN 21 1930 Reg.

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-20 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-2, 1930, to 1-20, 1930, that I last saw her alive on 1-20, 1930, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis

(duration) about years mos ds.

CONTRIBUTORY (Secondary): Myocardial Failure Surgical Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 1-20-30

Was there an autopsy? no

What test confirmed diagnosis? Question

(Signed) W B Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 BURIAL, CREMATION OR RE[illegible] DATE OF BURIAL: New Cathedral (Cemetery) Jan 23 30

20 UNDERTAKER: A. S. Marshall ADDRESS: 3539 Fallsway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 53229

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53229

CERTIFICATE OF DEATH. 1-6488-01

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No.) West Balto Gyne. Hospital Ward (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas George Holt Jr Elmer (Or, if not known, Age) 10 yrs. 11 mos. 28 ds.)

(Residence in Baltimore: No.) Batrman Apts Batrman St

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: January 23 (Month) (Day) 1919 (Year)

7-AGE: 10 yrs. 11 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer): Student

9-BIRTHPLACE, (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Thomas G. Holt

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Florence Marie Peat

13-BIRTHPLACE OF MOTHER, (State or Country): St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas G. Holt Jr
(Address) Batrman Apts

15-
Filed ..... 192.....
C. HAMPSON JONES, M. D. Registrar.

2-1 1930

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Jan (Month) 20 (Day) 30 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Ran into rear wheel of auto (Moving) while coasting on sled
as
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Fract Skull (Compound)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
1/21 1930 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? Bateman + Manor

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cemetery DATE OF BURIAL: Jan 23 1930

20-UNDERTAKER: Wm J Flanagan Sons ADDRESS Northern

is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53230

CERTIFICATE OF DEATH

172 E 53230

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH: Pronounced dead at

City of Baltimore: (No.) Johns Hopkins Hospital (St.) 2-4 (Ward)

2-FULL NAME: Joseph Maciang

(a) RESIDENCE NO. 618 S. Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Kazimerra Maciang

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
48	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Poland

PARENTS

10 NAME OF FATHER: Peter Maciang

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Poland

14 Informant: Kazimiera Maciang (wife)
(Address): 618 S. Wolfe St

15 Filed ..., 19... Registrar

JAN 21 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage-Cut his throat with razor-Then jumped out 3rd story windowk(Melancholia)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Injury to spine Oct 5/20

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Hamm, M. D.

1/21/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem

DATE OF BURIAL: 23 1930

20 UNDERTAKER: John M. Weigand

ADDRESS: Chester Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53231

CERTIFICATE OF DEATH

170 E 53231

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1100 W. Franklin St., 18th Ward)

2-FULL NAME Ferdinand L. Laumann

(a) RESIDENCE NO. 1100 W. Franklin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Katr Laumann

6 DATE OF BIRTH (month, day, and year) 2. 2. 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62	2	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Meat
(c) Name of employer Louis C Laumann

9 BIRTHPLACE (city or town) .....
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas L Laumann

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Katherine Bushmann

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto Md

14 Informant Louis C Laumann
(Address) Fullerton Md

15 Filed ....., 19.. J. HAMPSON JONES, M. D., Registrar
By .....

JAN 21 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to death (autopsy or inquiry)

on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide

Gun Shot of Head

Revolver

(duration) ..... yrs. ..... mos. — ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) A C Coates M. D.

. 19 (Address) 1436 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Jan 23rd 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53232

CERTIFICATE OF DEATH

46 E 53232

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2203 W Lafayette Ave (St.) (1626) (Hosp.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah F Lewis

(a) RESIDENCE NO. 2203 W Lafayette Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles H. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sarah Libey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Miss Mary A Forsythe

(Address) 2203 W Lafayette Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

By 2 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1928, to Jan. 20, 1930

that I last saw h[illegible] alive on Jan 18 1930

and that death occurred, on the date stated above, at 6 20 m.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Lawrence M. D.

1/20 1930 (Address) 18 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL Jan 23 1930

20 UNDERTAKER John F Denny — ADDRESS 715 Lig St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53233

CERTIFICATE OF DEATH

90 E 53233

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 522 Annabel Ave. St., 25-75 Ward)

2-FULL NAME Emma Elizabeth Schline.

(a) RESIDENCE NO. 522 Annabel Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed~~ ~~divorced~~
~~HUSBAND OF~~
(or) WIFE of George Schline.

6 DATE OF BIRTH (month, day, and year) May 5, 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Henry Chaney.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Clara Thorne.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New Jersey.

14 Informant George Schline. (husband)
(Address) 522 Annabel Ave.

15 Filed C. HAMPSON JONES, M. D. Registrar

21 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [signature], M. D.

1/21, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DATE OF BURIAL Jan 22 1930

20 UNDERTAKER John F. Denny ADDRESS 745 Lex

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

32966 E 53234 E 53234

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Steever

(a) RESIDENCE NO. Reisterstown ST. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Practical Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Ont

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Elisha Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Yard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to Jan 21, 1930, that I last saw her alive on Jan 21, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

inanition (cancer) of senile psychosis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? yes

(Signed) Urban Drechsler M.D.

1-21, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Ridge

DATE OF BURIAL Jan 24 1930

UNDERTAKER F. Berryman Sons

ADDRESS Reisterstown Md

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Wissig 4000 Edmondson Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53235

CERTIFICATE OF DEATH

129 E 53235

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4207 Groveland Ave WARD 53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Thomas Hinton

(a) RESIDENCE NO. 4207 Groveland Ave ST., W. Arlington WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Clara M.

6 DATE OF BIRTH (month, day, and year) Oct 6th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Com. Trader

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sam Frick Inst Co

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John T. Hinton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Virginia Gudgrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Irving D. Hinton

(Address) 2417 Harlem Ave

15 JAN 21 1930, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from ..., 1926, to Jan 20, 1930, that I last saw he alive on Jan 20, 1930 and that death occurred, on the date stated above, at 12:20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Cardiac Fibrillation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. L. Wissig, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 1/22/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53236

74-001

E 53235

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Belt st ST. 24-3H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie E. Holmes

(a) RESIDENCE NO. 1703 Belt st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. 2 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard W Holmes

6 DATE OF BIRTH (month, day, and year) Aug 2. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Richard W. Holmes

(Address) 1703 Belt st

15 Filed 2 1 1930, 19 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1930, to Jan 20, 1930

that I last saw h.e alive on Jan 20, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) C. F. Campbell M. D.

1, 20, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 1/22/1930

20 UNDERTAKER Wm Cook

ADDRESS 127 St Paul st

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53237

CERTIFICATE OF DEATH.

90 E 53237

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 218 S. Chapel ST., W. W. (WARD)

2-FULL NAME Thomas J. Dunphy

(a) RESIDENCE NO. 218 S. Chapel ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Mary Dunphy

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) M. & Schaul Plumbing Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Patrick Dunphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan Farren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant wife (Address) 218 S. Chapel St.

15 Filed ..... 19 .....

N 2 1930

H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1926, to Jan. 18, 1930, that I last saw him alive on Jan. 18, 1930, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

(Cerebral apoplexy
Chr. arteriosclerosis
Chr. Cardiitis.

(duration) 3 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Emil Zeigler, M. D.

1/ 1930 (Address) 700 E. Butt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Jan. 22 1930

20 UNDERTAKER Lilly & Jenkins ADDRESS 1000 E. Monument St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53238

CERTIFICATE OF DEATH

74-001 ✓

E 53238

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 240 Rock St ~~St.~~ 18-No ~~Ward~~)

2-FULL NAME Robert Dennis

(a) RESIDENCE NO. 240 Rock St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mr. Arley Jackson
(Address) 713 S. Clinton St

15 Filed ..... 19..... C. HAMPTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Zeller M. D.

1/21. 1930. (Address) 2323 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Actum Cem DATE OF BURIAL Jan 23 1930

20 UNDERTAKER Chas. H. Johnson ADDRESS 415 N. Carrollton Av.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JAN 22 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 53239 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 ✓ E 53239

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 9-46

CITY OF BALTIMORE: (No. ? ST., ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C Scott

(a) RESIDENCE NO. 2807 Simpson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? —yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Negro	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Henson Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? ?

12 MAIDEN NAME OF MOTHER Maggie Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Va.

14 Informant Records L (Address) BALTIMORE CITY HOSPITALS

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-20-30

17 I HEREBY CERTIFY, That I attended deceased from 1-14, 1930, to 1-20, 1930, that I last saw her alive on 1-20, 1930 and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension: Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin H McLean, M. D.

1-21, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL Jan 23 1930

20 UNDERTAKER Clive H. Johnson ADDRESS 418 N. Caroline St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53240

CERTIFICATE OF DEATH

38 E 53240

1—PLACE OF DEATH Balto City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No.) Balto Md ST. 47-43 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Lane

(a) RESIDENCE NO. 4119 White Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lane

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
75				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Post Office

(c) Name of employer Clerk

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Tinney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records (Address) Balto City Hosps

15 Filed JAN 2 1930 H. M. JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-19-30

17 I HEREBY CERTIFY, That I attended deceased from 10-2-, 1929, to 1-19, 1930

that I last saw him alive on 1-17, 1930

and that death occurred, on the date stated above, at 10:45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Paralysis

Coma

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cystic Infection

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Gross

(Signed) Harry Feldmann, M. D.

Jan. 19 30 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Dulaney Valley 1/24 1930

20 UNDERTAKER ADDRESS

Wm. H. Holland 1031 Druid Hill Ave

Spec.—2-29-28—L. F. S.—500 Blks

No Autopsy

E 53241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24 002

E 53241

REGISTERED NO.

1—PLACE OF DEATH Union Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 33rd & Calvert ST.) 12-19 WARD)

2—FULL NAME Frank L. Case.

(a) RESIDENCE NO. Linda Grand Apts University Parkway & 40th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Frank Case.

6 DATE OF BIRTH (month, day, and year) Dec 10, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Army Officer-Colonel

(b) General nature of industry, business, or establishment in which employed (or employer) Ret

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jeromeville Ohio.

PARENTS

10 NAME OF FATHER Talbert Case.

11 BIRTHPLACE OF FATHER (city or town) Mecca (State or country) Ohio

12 MAIDEN NAME OF MOTHER Caroline Libbee

13 BIRTHPLACE OF MOTHER (city or town) W. Farmington (State or country) Ohio.

14 Informant Hospital records

(Address)

15 Filed JAN 22 1930 H. LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Jan 20, 1930, that I last saw h-m alive on Jan 20, 1930 and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral embolus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Linda Grand Apts.

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frances W. Gluck M. D.

Jan 20th 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chattanooga Tenn

DATE OF BURIAL Jan 22 1930

20 UNDERTAKER Sol Lurman & Bro

ADDRESS 1127 E Balto St

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53242 — 31 ✓ — E 53242

1—PLACE OF DEATH — REGISTERED NO. _____

CITY OF BALTIMORE: (No. # 1837 W. Fairmount Ave. — WARD) 20-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A. Gateley

(a) RESIDENCE NO. 1837 ~~6 Gilo~~ W. Fairmount Ave. — WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22nd, 1891

7 AGE	Years	Months	Days 27	If LESS than 1 day, ___ hrs. or ___ min.
	38	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Patrick Gateley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget McGreal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Bridget A. Gateley

(Address) # 1837 W. Fairmount Ave

15 Filed _____ 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929. to Jan. 19, 1930.

that I last saw h. l. alive on Jan 19, 1930

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam etc.

(Signed) S. Chesney Lowe, M. D.

1/21. 1930 (Address) 888 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. — DATE OF BURIAL: Jan 23, 1930.

20 UNDERTAKER: John J. Cowan & Son — ADDRESS: 901 Hollins

Important. See instructions on back of certificates.

Spec.—8-16-29—L. P. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53243

CERTIFICATE OF DEATH

E 53243

REGISTERED NO. 4-08

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. # 26 S. Poppleton ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M. Cronise

(a) RESIDENCE NO. # 26 S. Poppleton ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 1 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna G. Cronise

6 DATE OF BIRTH (month, day, and year): Feb 4, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boiler maker

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Bartlett & Hayward Co

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John N. Cronise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Anna G. Cronise

(Address): # 26 S. Poppleton St.

15 Filed JAN 22 1930, [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 21, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to Jan. 21, 1930, that I last saw h[illegible] alive on Jan 21, 1930 and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ... yrs. ... mos. 4 da.

CONTRIBUTORY (Secondary) Artery Sclerosis

(duration) 6 yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam Etc.

(Signed) Chas. Thornton, M. D.

1/21, 1930 (Address) 888 N. Loudon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Jan 23, 1930.

20 UNDERTAKER: John J. Cowan & Son — ADDRESS: 901 Hollins

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53244

CERTIFICATE OF DEATH

49

E 53244

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Hospital St. 16-23 Ward)

2-FULL NAME William Fitzhugh

(a) RESIDENCE NO. 1005 Laudale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Fitzhugh

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Fitzhugh

11 BIRTHPLACE OF FATHER, (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mahala —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Frances Fitzhugh

(Address) 2401 Madison Ave

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1930

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tumor of Mediastinum

(duration) 6 yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Ca Larynx

(duration) ..... yrs. ..... mos. ..... ds.

18 Where did disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) G C Slade, M. D.

. 19 (Address) 143 W Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 23 19 30
20 UNDERTAKER	ADDRESS
Samuel E. Kennedy	Linden

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53245 — CERTIFICATE OF DEATH — 3 | E 53245

REGISTERED NO. 2

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 2820 Fot ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarine Gladeus Mosteller

(a) RESIDENCE NO. 2820 Fot ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md

PARENTS

10 NAME OF FATHER John N. Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elizabeth Wright

(Address) Forest P.O. Md

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 20 30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19, 1930, to Jan. 20, 1930,

that I last saw h.. alive on Jan 20, 1930

and that death occurred, on the date stated above, at 5-40 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

Tuberculosis (duration) yrs. mos. ds.

CONTRIBUTORY — (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) P. Gardner Steele, M. D.

Jan 21, 1930 (Address) 1534 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marks Cem. DATE OF BURIAL Jan 22 30

20 UNDERTAKER Samuel L. Hensley ADDRESS Baltimore

Important. See instructions on back of certificates.

JUN 2 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53246 | CERTIFICATE OF DEATH | 129 E 53246

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Mosher ST. 16-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia E.H.Jones,

(a) RESIDENCE NO. 1817 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Berry T.J.B.Jones,

6 DATE OF BIRTH (month, day, and year) March 27, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82	9	25 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Somerset Co.Md.

PARENTS

10 NAME OF FATHER William Bailey,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co.Md.

12 MAIDEN NAME OF MOTHER Susan Covington,

11 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co.Md.

14 Informant Miss Susie B. Jones (Address) 1817 McMechen St

15 JAN 22 1930 [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930, to Jan 21, 1930, that I last saw h[illegible] alive on ..., 19..., and that death occurred, on the date stated above, at 7 20 A. m.

The CAUSE OF DEATH* was as follows:

Edema Pulmonalis Bilateral Nephritis Chronic

(duration) 3 m 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis + Hypertension (duration) 5 yrs — mos — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual,

(Signed) M B Sumwalt, M. D.

1/22, 1930 (Address) 626 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL JAN 24, 1930

20 UNDERTAKER Geo W Little

ADDRESS 2709 ERDMAN AVE.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53247

E 53247

CERTIFICATE OF DEATH

129

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE South Baltimore Gen. Hospital (WARD)

2—FULL NAME Miss Lottie Stevens

(a) RESIDENCE NO. 1332 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany. 13-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	50	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Robert F. Stevens

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Joyce

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mr. Walter Stevens (Address) Balto Md.

15 Filed JAN 22 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21-30

17 I HEREBY CERTIFY, That I attended deceased from 1-15, 1930, to 1-21, 1930

that I last saw h[illegible] alive on 1-21, 1930

and that death occurred, on the date stated above, at 2.40a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumona

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardio-Vascular Renal Disease (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Lalukaitis, M. D.

19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 1/23 1930

20 UNDERTAKER L. Few McCarthy

ADDRESS 130 E. Fort.

Important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

E 53248

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53248

CERTIFICATE OF DEATH.

47

REGISTERED NO. 9204

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1942 N. Fayette ST. (or WARD) 20

2-FULL NAME Sadie A. Phoebus

(a) RESIDENCE. No. 1942 N. Fayette ST., 20 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Phoebus

6 DATE OF BIRTH (month, day, and year) Feb 14-1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll co Md

PARENTS

10 NAME OF FATHER Basel Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER Margaret Harp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Carroll co

14 Informant John M. Phoebus (Address) 1942 N. Fayette St

Filed JAN 22 1930 19 R. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 20, 1930,

that I last saw h[illegible] alive on Jan 20 1930,

and that death occurred, on the date stated above, at 1.35 A m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart following intestinal obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 16-1930

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hattie E. Tuckerman, M. D.

Jan 21 1930 (Address) 2002 N. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mangan Chapel Woodbine	Jan 23 1930
20 UNDERTAKER	ADDRESS
Jos Jourdans & Son	2173 Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53249 — 129 ✓ — E 53249

CERTIFICATE OF DEATH

REGISTERED NO. 1631

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 S. Conkling ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Barr

(a) RESIDENCE NO. 714 S. Conkling ST. 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Barr

6 DATE OF BIRTH (month, day, and year) May 15th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68 69	8	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Dont Know.

11 BIRTHPLACE OF FATHER (city or town) New York
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant Harold Barr
(Address) 714 S Conkling St

15 Filed 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 19, 1930, that I last saw her alive on Jan 19, 1930, and that death occurred, on the date stated above, at 11 49a m.

The CAUSE OF DEATH* was as follows:

Uraemia — 3 days —
Myo cardial failure (1 day) —
Chr. Nephritis — } 2 yrs.
Cardio-Vas cular-renal disease } 2 yrs.
(duration) yrs. mos. da.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Gross-phy. exam —

(Signed) Louis F. Krumeich, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Jan. 22 1930
20 UNDERTAKER Lilly + Zeiler	ADDRESS 4033 S. Wolfe St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Gowdkes ·

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53250

REGISTERED NO. E 53250

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 926 N. Sterling St. WARD 14

2—FULL NAME Walter Fowlkes

(a) RESIDENCE NO. 926 N. Sterling St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Fowlkes

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Daniel Fowlkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Minnie Fowlkes

(Address) 926 N. Sterling st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-20-30

17 I HEREBY CERTIFY, That I attended deceased from 10-15- 1929, to 1-20- 1930, that I last saw h alive on 1-18- 1930 and that death occurred, on the date stated above, at 2,30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1-21- 1930 (Address) 611 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holloway Co. Va	Jan 23, 1930
20 UNDERTAKER M. V. G. Elliott	ADDRESS 1925 Ashland Av.

Important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53251

E 53251

CERTIFICATE OF DEATH.

REGISTERED NO. 111-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2131 McCulloh St. WARD) 14-20

2-FULL NAME James E. Thomas

(a) RESIDENCE NO. 2131 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Carrie Thomas

6 DATE OF BIRTH (month, day, and year) May 30, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Shell Pile

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Michaels Md

PARENTS

10 NAME OF FATHER David Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie Thomas

(Address) 2131 McCulloh St

15 Filed JAN 22 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Jan 17, 1930, that I last saw him alive on Jan 17, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Typhus Fever - Perforating?

(duration) yrs. 1 mos. 7 da.

CONTRIBUTORY (Secondary) Indigestion

(duration) yrs. ? mos. da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

1/21, 1930 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery DATE OF BURIAL Jan 22, 1930

20 UNDERTAKER Mrs. A. A. Elliott ADDRESS 1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53252

CERTIFICATE OF DEATH

75-B02 E 53252

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 321 N Pulaski St. 20-69 Ward)

2-FULL NAME Gretta Frischcourt

(a) RESIDENCE NO. 321 N Pulaski St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 Color or Race White | 5 Single, Married, Widowed or Divorced. (Write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1871

7 AGE Years 53 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Peter Lenard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) France

12 MAIDEN NAME OF MOTHER Mbundem

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) France

14 Informant Gretta McGee
(Address) 321 N Pulaski

15 Filed ..... 193.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1930

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Paralysis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) J. C. Wades, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL 1/27/30

20 UNDERTAKER Jos. O. Farley Sons — ADDRESS Baltimore

ANZ 2 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53253

E 53253

CERTIFICATE OF DEATH

REGISTERED NO. 9-46 161-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Ramsland

(a) RESIDENCE NO. 2817 Kennedy ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 18, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER S-B- Ramsland

11 BIRTHPLACE OF FATHER (city or town) Norway (State or country)

12 MAIDEN NAME OF MOTHER Thyrdis ~~Thoresen~~

13 BIRTHPLACE OF MOTHER (city or town) Norway (State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 22 1930, 19 RLL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19-30

17: I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Jan 19, 1930, that I last saw h[illegible] alive on Jan 19, 1930 and that death occurred, on the date stated above, at 11 15 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) C. O. 4. Warren, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 22 1930, 19

20 UNDERTAKER Commissioner Health.

ADDRESS JAN 22 1930

Per Chas E. Woods

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 53254

REGISTERED NO. E 53254

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Ellwood ave ST. 611 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arben M. Bobbitt Jr

(a) RESIDENCE NO. 5 N Ellwood ave ST. 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jany 17-30

7 AGE: Years — Months — Days 4 — If LESS than 1 day, hrs. or min. 13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Arben M. Bobbitt

11 BIRTHPLACE OF FATHER (city or town) Pattonville (State or country) Va.

12 MAIDEN NAME OF MOTHER Florence Fizer

13 BIRTHPLACE OF MOTHER (city or town) Pattonville (State or country) Va.

14 Informant (Address) Father 5 N Ellwood ave

15 [illegible] 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 17 1930 to Jany 21 1930 that I last saw he alive on Jany 21 1930 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) O. L. Long M. D.

1/22, 1930 (Address) 3211 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Jan 22 1930

20 UNDERTAKER John A. Moran — ADDRESS 3000 E Balto St

JAN 22 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 53255

CERTIFICATE OF DEATH

49 E 53255

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Collins Ave. ST. 20-71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Calvin Ring

(a) RESIDENCE NO. 122 Collins Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 2, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wesley W. Ring

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel

(State or country) County, Md.

12 MAIDEN NAME OF MOTHER Susie May Shubbard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mr. Wesley Ring

(Address) 122 Collins Ave.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to Jan 21, 1930, that I last saw him alive on Jan 13, 1930, and that death occurred, on the date stated above, at 10.20 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Right Kidney

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Late May 1929.

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) J. Lloyd Johnson M. D.

1/22, 1930 (Address) Augusta & Frederick Aves.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Jan. 23 1930

20 UNDERTAKER Dec 19 Cook

ADDRESS 1003 West Baltimore St

Important. See instructions on back of certificate.

Spec.—12-9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53256

E 53256

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2138 E Federal St. 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Bonhage

(a) RESIDENCE NO. 2138 E Federal St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Bonhage

6 DATE OF BIRTH (month, day, and year): March 2, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Brewery

(b) General nature of industry, business, or establishment in which employed (or employer): Worker 86

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: August Bonhage

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Schaeffer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs Katherine Bonhage

(Address) 2138 E Federal Street

C. H. Wilson JONES, M. D.

Registrar

N 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1930, to Jan 20, 1930, that I last saw him alive on Jan 19, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Inactivity & Overweight (duration) 4 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fred L. Zimmerman, M. D.

1-20 1930 (Address) 2858 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

Date of Burial: 1/23 1930

20 UNDERTAKER: Albert L. Hilty

ADDRESS: 1606 Chester St

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53257

CERTIFICATE OF DEATH

101-001 ✓ E 53257

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp (STREET) 2435 (WARD)

2—FULL NAME Julius Lowe

(a) RESIDENCE NO. 1404 Decatur St ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore 07

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Hospital Record
(Address) .....

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21-30

17 I HEREBY CERTIFY, That I attended deceased from 1-20, 1930, to 1-21, 1930, that I last saw h[illegible] alive on 1-21, 1930 and that death occurred, on the date stated above, at 5-30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia - right lung

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Empyema right side

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Alms house

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Lumpkin, M. D.

1-21, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem	Jan 25 1930
20 UNDERTAKER Chas L. Stearns	ADDRESS 1501 E Fort Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 29 ✓ E 53258

REGISTERED NO. 25-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2247 Cedley St (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles H. Harlman

(a) RESIDENCE NO. 2247 Cedley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Fisher.

6 DATE OF BIRTH (month, day, and year) Oct 13 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
43 54	3	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Drugs

(c) Name of employer Pickin Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles Harlman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Ida Harlman

(Address) 2247 Cedley St.

15 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/3 —, 1930 to 1/20 —, 1930, that I last saw h— alive on 1/20 —, 1930 and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Dilated Heart

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) — yrs. — mos. 3 ds

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Kaufmann M. D.

19 (Address) 1340 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Jan 24 1930

20 UNDERTAKER Chas. L. Stevens

ADDRESS 15 E Fort Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53259 — REGISTERED NO. E 53259

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1246 Cleveland St.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evan T. Scott

(a) RESIDENCE NO. 1246 Cleveland St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha P. Scott

6 DATE OF BIRTH (month, day, and year) July 30, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer of Antiques

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Evan Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bertha P. Scott (Address) 1246 Cleveland St.

15 Filed [illegible] 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 30.

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1929 to Jan 21st 1930.

that I last saw him alive on Jan. 20th 1930

and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

General debility

CONTRIBUTORY (Secondary) Head trauma (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. Coulbourn M. D.

1/21/1930 (Address) 3909 Gamson Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL Jan 24, 1930.

20 UNDERTAKER Mrs. John H. Tempel & Son ADDRESS 801 N. Fayette

Important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 53260

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53260

CERTIFICATE OF DEATH.

161-001

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1532 W. Fairmount St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Boy Butler

(a) Residence No. 1532 W. Fairmount St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan. 17-1930

7-AGE. ..... yrs. ..... mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. .....

(b) General nature of industry, business, or establishment in which employed (or employer). .....

(c) Name of employer. .....

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Md.

PARENTS.

10-NAME OF FATHER William Pair

11-BIRTHPLACE OF FATHER (city or town) Unknown
(State or Country).

12-MAIDEN NAME OF MOTHER Verona Butler

13-BIRTHPLACE OF MOTHER (city or town) Canada
(State or Country). Can.

11- (Informant) Mrs. Just Butler

(Address) 1532 W. Fairmount Ave.

15- Filed ..... 19 C. HAMPSON JONES, M. D. Registrar.

JAN 22 1930 By .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 21-1930

17- I HEREBY CERTIFY, That I attended deceased from Jan. 17 1930 to Jan. 20 1930

that I last saw him alive on Jan. 20 1930

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Prematurity (36 wks)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Louis H. Douglass M. D.

1/22 1930 (Address) Emil Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mount Auburn

DATE OF BURIAL. Jan. 23 1930

20-UNDERTAKER. Joseph A. Lively

ADDRESS 409 N. Mount Street

instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53261

CERTIFICATE OF DEATH

90 E 53261

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Brown

(a) RESIDENCE NO. 232 N. Pearl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James H. Samuels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Silas ?

12 MAIDEN NAME OF MOTHER Md.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-16-30

17 I HEREBY CERTIFY, That I attended deceased from 1-4-30, 19..., to 1-16-30, 19...,

that I last saw her alive on 1-16-30, 19...

and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) over 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension. Arteriosclerosis. Aortic Insufficiency (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

1-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JAN 22 1930

20 UNDERTAKER Commissioner Health

ADDRESS

Wm. M. Woodall

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53262

CERTIFICATE OF DEATH

REGISTERED NO. 90

E 53262

1—PLACE OF DEATH Balto. City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 19-37 ST. WARD)

2—FULL NAME Louis Crowder

(a) RESIDENCE NO. 406 N. Bruce ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male	Colored	UNKNOWN

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of [redacted] Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Deets Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Tillie Crowder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Balto. City Hospitals

15 [illegible] C. HAMPSON JONES, M. D. (Registrar)

JAN 22 1930 of 1285 Ward

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-19-30

17 I HEREBY CERTIFY, That I attended deceased from 11-20-29, 19..., to 1-19-30, 19..., that I last saw him alive on 1-19-30, 19..., and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McLean, M. D.

1-20, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAN

DATE OF BURIAL JAN 22 1930 19...

20 UNDERTAKER

ADDRESS

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53263

CERTIFICATE OF DEATH

8

E 53263

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 6-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Janssen

(a) RESIDENCE NO. 422 N. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 2 mos. 13 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 9, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	9	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of Industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Janssen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Rose Eaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Rose Janssen

(Address) 422 N. Curley St

15 FILED JAN 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930 to Jan 22, 1930

that I last saw him alive on Jan 21, 1930

and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) 0 yrs. 0 mos. 9 da.

CONTRIBUTORY Acute cervical adenitis

(Secondary) acute nephritis (duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? 422 N. Curley St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Clark M. D.

1-22, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill

DATE OF BURIAL Jan 23, 30

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

important. See instructions on back of certificates.

E 53264

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 V

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 2607 N. Charles St. (WARD) 17-50

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Washington Booth Booz

(Residence in Baltimore: No. 2607 N. Charles St St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widower

6-DATE OF BIRTH. Nov (Month) 8th (Day) 1856 (Year)

7-AGE. 73 yrs. 2 mos. 13 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired Atty
(b) General nature of industry, business, or establishment in which employed (or employer). Shipbuilding

9-BIRTHPLACE. (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Chas. N. Booz

11-BIRTHPLACE OF FATHER (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER Harriet Shinnick

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen M. Booz

(Address) 2607 N. Charles St

15- C. HAMPSON JONES, M. D.

Physician. Address.

JAN 22 1930 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. 1-21- (Month) (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

C Bronchitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John H. Cornman M. D.
(Coroner)

1-22- 1930 (Address) 769 E. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Green Mount

DATE OF BURIAL. Jan. 23. 1930

20-UNDERTAKER. Henry W. Jenkins Sons

ADDRESS. McCulloh & Eutaw St.

Spec.—1-10-21—MAT—1500 Blks.

E 53265 **HEALTH DEPARTMENT—CITY OF BALTIMORE.** 101-201 ✓

CERTIFICATE OF DEATH. 101-201 E 53265

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 S. Ann St. ST. 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeline Cooley

(a) RESIDENCE NO. 310 S. Ann St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 10 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Carrol Cooley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montereal Can.

12 MAIDEN NAME OF MOTHER Constance Patter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Constance Cooley

(Address) 310 S. Ann St.

15 Filed N 2 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930 to Jan 21, 1930.

that I last saw her alive on Jan 21, 1930

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Lob Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph H. Wahlstrom, M. D.

(Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus

DATE OF BURIAL Jan 23 1930

UNDERTAKER John M Weber

ADDRESS 701 E Chester St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

Houck. Appd. ✓ M. Lee

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53266

CERTIFICATE OF DEATH

90 E 53266

1—PLACE OF DEATH

REGISTERED NO. 15-71

CITY OF BALTIMORE: (No. 1802 Baker ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Dolly Clark

(a) RESIDENCE NO. 1802 Baker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Patrick

6 DATE OF BIRTH (month, day, and year) Jan 5 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Romaine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Bessie Wolf

(Address) 1802 Baker St.

15 Filed JAN 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1/29, 19.., to Jan 21/30, 19.., that I last saw ... alive on Jan 20/30, 19.., and that death occurred, on the date stated above, at 7-30 P.M.

THE CAUSE OF DEATH* was as follows:

Chronic Pneumonia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arthritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C. Edward Lee M. D.

Address 1929 Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 24 1930

20 UNDERTAKER Hm Cook ADDRESS 1217 St Paul

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53267

CERTIFICATE OF DEATH

101-001 V E 53267

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Gen'l Hospital St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Charles Watts

(a) RESIDENCE NO. 3206 Independent St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11, 1922

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	7	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —0—

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Glenburnie

(State or country) Maryland

PARENTS

10 NAME OF FATHER Howell Watts

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillian Layman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JAN 22 1930 19 J. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from

1-8-30 19 to 1-22 1930

that I last saw h~~im~~ alive on 1-22 1930

and that death occurred, on the date stated above, at 6¹⁰ A m.

The CAUSE OF DEATH* was as follows:

Pancreatitis, (6 mos.)
Bilateral Lobar Pneumonia

(duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary)

Toxemia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1/27/30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem.

Date of Burial 1/25 1930

20 UNDERTAKER Wm Cook

ADDRESS 1215 E. Lan[illegible]

JAN 22 1930

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

4/E 53268

CERTIFICATE OF DEATH

E 53268

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 185 Welcome Al. St. 12-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Dawkins.(C)or Richard Lockhart.(C)

(a) RESIDENCE NO. 185 Welcome Al. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, HUSBAND of Maggie Dawkins.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	84	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Maggie Dawkins.(C)(wife)
(Address) 185 Welcome Al.

Filed 19 C. HAMILTON JONES, M. D. Registrar

JAN 23 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 21, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicaemia.
Punctured wound of foot by rusty nail.
Accidental death.
(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. C. Eppinghardt, M. D.

1/21. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gastonia, N.C.	Jan 23 1930
20 UNDERTAKER A. L. Brown & Son	ADDRESS 618 W. Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53269 — 24-001 — E 53269

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-58

CITY OF BALTIMORE: (No.) 3614 Cottage Ave ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Lewis Kronberger

(a) RESIDENCE NO. 3614 Cottage Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 2 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Palmyra V. Kronberger

6 DATE OF BIRTH (month, day, and year) July 17-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Carl Kronberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Derr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles L Kronberger

(Address) 3617 Sprunsdale

15 JAN 23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan-18, 1930, to Jan-21, 1930,

that I last saw him alive on Jan-21, 1930

and that death occurred, on the date stated above, at 4-07 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, with Right Hemiplegia and respiratory phenomena

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senile Arterio-sclerosis

(duration) .7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Wesley Cole, M. D.

1/22 1930 (Address) 2202 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 23, 1930
UNDERTAKER H. J. Rodgers Son	ADDRESS Mt Pleasant

Cor.—19-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53270 ✓ 84 E 53270

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Linden Ave & Mc Mechen St. (Ward) 28

2-FULL NAME David Paulson

(a) RESIDENCE NO. 8 Lehigh Parkway East Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Paulson

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sect. Jdy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Abraham Paulson

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Lockie

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Dr. Morris Paulson
(Address) 1401 Eutaw Pl.

15 Filed JAN 23 1930 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. E. Buck, M. D.

Jan 21 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	1/23 1930
20 UNDERTAKER Jack Laws	ADDRESS 1439 E. Baltimore St

Do not write in this space. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53271

CERTIFICATE OF DEATH

129 E 53271

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2230 Eutaw Pl. (ST.) 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anne Michelson

(a) RESIDENCE NO. 2230 Eutaw Place WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., If foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Rudolph A.

6 DATE OF BIRTH (month, day, and year): Dec 24 1886

7 AGE: Years 44 | Months | Days 29 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kurland Russia

PARENTS

10 NAME OF FATHER: Simon Michelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kurland Russia

12 MAIDEN NAME OF MOTHER: Etka Racunin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kurland Russia

14 Informant: Lillian B. Michelson

(Address) 4418 Forest Park Ave.

15 Filed JAN 23 1930, 19 H. C. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from September 18, 1929, to January 22, 1930, that I last saw h.. alive on January 21, 1930 and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Hypertension (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Samuel Wolman, M. D.

I-22, 1930 (Address) 2444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem.

DATE OF BURIAL: 1/23 1930

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 Eutaw St

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 53272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 E 53272

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 2021 Druid Hill Ave (ST.) 14 (WARD)

2-FULL NAME Samuel Richard Bishop

(a) RESIDENCE NO. 2021 Druid Hill Ave (ST.) 14 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Martha Bishop

6 DATE OF BIRTH (month, day, and year) March 13 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Madison Dorchester Co Md.

PARENTS

10 NAME OF FATHER Abraham Bishop

11 BIRTHPLACE OF FATHER (city or town) (State or country) British Guiana

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Madison Dorchester Co, Md.

14 Informant Wingfield Bishop (Address) 2021 Druid Hill Ave

15 JAN 23 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20/1930

17 I HEREBY CERTIFY, That I attended deceased from 12/29/1929 to 1/20/1930 that I last saw him alive on 1/20/1930 and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory failure following Uremia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cystitis; Pyelitis (?)

(duration) ... yrs. ... mos. 22 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical & History

(Signed) W. S. Bishop, M. D.

, 19 (Address) 709 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Jan 25 1930

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Pound Ave

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53273 ✓ 47 ✓ E 53273

CERTIFICATE OF DEATH

REGISTERED NO. 15-21

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 N. Fulton Av St.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura M. Lightner

(a) RESIDENCE NO. 2014 N. Fulton Av ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. — mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced (or) WIFE of Walter S. Lightner

6 DATE OF BIRTH (month, day, and year) Sept. 23-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Wm P. Peiffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Rebecca Getz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Dr. Walter S. Lightner (Address) 2014 N. Fulton Av

15 [illegible] 23 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 24 1930

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 24 to Jan 24 1930

that I last saw h er alive on Jan 24 1930

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast
Beginning 6 yrs ago
Operated Recurred Mets pleura
debilitation 6 yr (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rt lung + thoracic vertebrae (duration) 2 yrs. mos. ds.
Gemme 6 yr remission

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3 or 4 past 6 yr

Was there an autopsy? no

What test confirmed diagnosis? X ray + Physical

(Signed) [illegible] M. D.

Jan 24 1930 (Address) 1744 W. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Jany 24 1930
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. North Av

Important. See instructions on back of certificate.

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53274

CERTIFICATE OF DEATH

E. 4-25 12

E 53274 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1020 Fayette St., 4-25 Ward)

2-FULL NAME Lehrer-Esser

(a) RESIDENCE NO. 1020 ~~Conn~~ Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col. | 5 Single, Married, Widowed or Divorced, (write the word): M Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1889

7 AGE: Years 41 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tailor 040
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Budapest
(State or country): Hungary

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Virginia Boyer

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Balto.

14 Informant: Wilhamina
(Address): 906 Argyle

15 Filed: APR 23 1930 Registrar: Reif

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 17. 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. T. Riley. Coroner M. D.

Jan. 21 1930 (Address) 1632 Bank

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem.

DATE OF BURIAL: 1—23 1930

20 UNDERTAKER: Byron & Wright 1218 McElderry

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53275

CERTIFICATE OF DEATH

31 ✓ E 53275

1—PLACE OF DEATH Baltimore City Hospt

REGISTERED NO. 12-51

CITY OF BALTIMORE: (No. Balto Md ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah McGease

250 Calvert St.

(a) RESIDENCE NO 1223 Union St S W ST., WARD

(Usual place of abode) Washington D C Unknown

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 87

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) Balto City Hospt

15 Filed ... 19 ... Registrar

1 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-20-30

17 I HEREBY CERTIFY, That I attended deceased from 11-12-, 1929, to 1-20-, 1930, that I last saw h[illegible] alive on 1-19-, 1930 and that death occurred, on the date stated above, at 1:10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Mary F. Gilmore M. D.

1/20, 1930 (Address) Baltimore City Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL January 23 1930

20 UNDERTAKER Samuel E. Newsley ADDRESS 5[illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

E 53276 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 53276

CERTIFICATE OF DEATH

REGISTERED NO. 17-76

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Wambach

(a) RESIDENCE NO. 750 W. Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 10 mos. 16 da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6 Unknown 51

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS

10 NAME OF FATHER August Wambach

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Peppler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant City Hospital Record
(Address)

15 Filed JAN 23 1930, 19 H. LAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22-30

17 I HEREBY CERTIFY, That I attended deceased from 6-12, 1929, to 1-22, 1930,
that I last saw h alive on 1-22, 1930
and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

(duration) Unknown mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. C. Champion, M. D.

1-22, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery Jan 24

DATE OF BURIAL Jan 24 1930

20 UNDERTAKER W M Montson

ADDRESS 223 S Pk Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53277

E 53277

CERTIFICATE OF DEATH

70-27 18/001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1817 W. Franklin St. Ward)

2-FULL NAME Annie C. O'Ferrall

(a) RESIDENCE NO. 1817 W. Franklin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) -------

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
About	80	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Ireland

PARENTS

10 NAME OF FATHER John O'Ferrall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie ----

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Alfred J. O'Ferrall
(Address) 200 N. Augusta Avenue

15 Filed ... 19... C. Hunter Pedigo M. D. Registrar

JAN 23 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Accident)

Gas Poisoning (Illuminating)

(duration) ... yrs. ... mos. — da.

CONTRIBUTORY (Secondary) Asphyxia

(duration) ... yrs. ... mos. — da.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What were confirmed diagnosis? —

(Signed) C. C. Hades, M. D.

. 19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 1/25 1930

20 UNDERTAKER Henry U. Mears & Son

ADDRESS Fred H. Calvert

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53278 ✓ E 53278

E 53278

CERTIFICATE OF DEATH

90

REGISTERED NO. 46-67

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3013 - Annah ST. WARD)

2—FULL NAME John McLaughlin.

(a) RESIDENCE NO. 3013 - Annah ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose McLaughlin. Devlin.

6 DATE OF BIRTH (month, day, and year) 6/5/1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Prop.

(b) General nature of industry, business, or establishment in which employed (or employer) Moving Picture

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER James McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa.

12 MAIDEN NAME OF MOTHER Catherine McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Pa.

14 Informant John McLaughlin

(Address) 3013 - Annah Av.

15 Filed JAN 23 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Jan 20, 1930, that I last saw h alive on Jan 20, 1930 and that death occurred, on the date stated above, at 11 1/4 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mesenteric

Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) W. L. Dabney M. D.

, 19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila Pa

DATE OF BURIAL Jan. 24 1930

20 UNDERTAKER George F. Roth

ADDRESS 1735 Harford av

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 53279

REGISTERED NO. 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2907 Bernard ST. 12-51 WARD)

2—FULL NAME Cora L. Thompson

(a) RESIDENCE NO. 2907 Bernard ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Joseph Allen Thompson

6 DATE OF BIRTH (month, day, and year) March 11, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Joseph Fatham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cora L. Fatham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Thomas J. Saddler.

(Address) 2907 Bernard St

15 Filed JAN 23 1930 [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from January, 1928, to January 21, 1930, that I last saw h.e alive on January 9, 1930 and that death occurred, on the date stated above, at 8:03 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & stethoscope

(Signed) Jack J. Singer, M. D.

, 19 (Address) 1208 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemy. Stoney. Co.	Jan 24 1930
20 UNDERTAKER	ADDRESS
Geo. A. Rust	1735 Harford Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53280 — 74-00 — E 53280

CERTIFICATE OF DEATH

REGISTERED NO. 27-48

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6015 Sycamore ST., (WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gideon P. Hopkins

(a) RESIDENCE NO. 6015 Sycamore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Irand Hopkins

6 DATE OF BIRTH (month, day, and year): Apr 24 1852

7 AGE: Years 77 Months 9 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Insurance Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: William B. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Boring

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant's (Address): Leon Hopkins 6015 Sycamore

15 Filed JAN 23 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 21 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1930 to Jany 21, 1930.

That I last saw h[illegible] alive on Jany 21, 1930

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? As usual

(Signed) Wm. J. Gilbert M. D.

, 19 (Address) 415 Cedarcroft Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laraine Lawn

DATE OF BURIAL: 1/23 1930

20 UNDERTAKER: J. A. Moran

ADDRESS: 399 E Baltimore

Spec.—2-29-28—L. F. S.—500 Blks.

E 53281

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 53281

CERTIFICATE OF DEATH

REGISTERED NO. 19-26

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 Saratoga ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary R. Walker

(a) RESIDENCE NO. 1303 Saratoga ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Wm. H. Walker

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Philip Steward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sardonia Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary V. Walker

(Address) 1303 W. Saratoga St

15 Filed ___ 19 ___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 19/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1929, to Jany 19, 1930, that I last saw her alive on Jany 19, 1930, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) —

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ___

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank E. Wasuth, M. D.

1/22/1930 (Address) 1606 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Jan. 22 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans Street

JAN 23 1930

Spec.—2-29-28—L. F. S.—500 Bks.

Henry Jones. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 53282

CERTIFICATE OF DEATH

E 53282

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 W. Montg. St. Montgomery 22-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Jones

(a) RESIDENCE NO. 111 W. Mont. ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Jones

6 DATE OF BIRTH (month, day, and year) Feb 28, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Amelia Co Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Henrietta Jones

(Address) 111 W Montgomery St

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Jan 19, 1930

that I last saw h[illegible] alive on Jan 8, 1930

and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows: Pneumonia, Lobar

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observations & Symptoms

(Signed) Chas. H. Flowers M. D.

Jan 20 19 30 (Address) 714 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Jan 23, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 922 N Schroeder St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 ✓

E 53283

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3516 Lucile Ave WARD) 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lewis Habb Rice

(a) RESIDENCE NO. 3516 Lucile Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Rice

6 DATE OF BIRTH (month, day, and year) Aug. 24 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie Habb

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Eva Rice

(Address) 3516 Lucile Ave

15 Filed JAN 29 1930 19 R. MARION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 29 to Jan. 22 19 30; that I last saw him alive on Jan. 20, 19 30 and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) about 6 mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical comm.

(Signed) Nathan Hunt M. D.

19 (Address) 2318 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 1/24/1930

20 UNDERTAKER David Sondheim

ADDRESS 15-25 W. Mt. Royal Ave

Important. See instructions on back of certificate

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53284

CERTIFICATE OF DEATH

90 E 53284

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1501 Mullikin St., 6-9 Ward)

2-FULL NAME Sophia Just

(a) RESIDENCE NO. 1501 Mullikin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Just

6 DATE OF BIRTH (month, day, and year) May 1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Czackowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown / Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant John Just
(Address) 1501 Mullikin St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Jan 21/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

1/22/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	Jan 24 1930
20 UNDERTAKER	ADDRESS
George A. Weber	705 S. Ann st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 53285

E 53285

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 18-N WARD)

2—FULL NAME Louise Gerber

(a) RESIDENCE NO. 1014 Boyd St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Gerber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Katherine Hasselman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Records of
(Address) Balto. City Hospitals

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21-30

17 I HEREBY CERTIFY, That I attended deceased from 11-27-26, 19..., to 1-21-30, 19..., that I last saw her alive on 1-21-30, 19..., and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

Idiopathic Epilepsy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harris M. McLean, M. D.

1-22 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Jan 25th 1930
20 UNDERTAKER	ADDRESS
John J. Cowan & Son.	501 Cathedral St.

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 53286

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 53286

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (NO. Caton & Wilkens Aves ST. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Klein

(a) RESIDENCE NO. 1003 W. Fayette ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Unknown 1831

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Retired Soldier.

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Adam Klein.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Name) Mamie Kreer (Address) 1003 W. Fayette St.

15 Filed ..... 19..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-10, 1930, to 1-22, 1930.

that I last saw h alive on 1-22, 1930.

and that death occurred, on the date stated above, at 5 20 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of 1-13-30

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Ernest Spencer Jr. ....., M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St Peters Cemetery

DATE OF BURIAL Jan 25 1930

20 UNDERTAKER John F. Cowan & Son

ADDRESS Govanstown, Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

TION is very important.

JAN 23 1930 [illegible] M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

Deares

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001

E 53287

CERTIFICATE OF DEATH

E 53287

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2912 Odonnell ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Dolores Soares

(a) RESIDENCE NO. 2912 Odonnell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) June 28 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
		6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ~~600~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Soares

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Katie Kahler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant George Soares

(Address) 2912 Odonnell st

JAN 23 1930 Filed ~~24 HOURS~~ M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-23-1930

17 I HEREBY CERTIFY, That I attended deceased from 1-22-30, 19..., to 1-23-30, 19..., that I last saw h~~e~~r alive on 1-22-, 1930 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Spinal Meningitis

(duration) ~~yrs.~~ ~~mos.~~ 2 ds.

CONTRIBUTORY (Secondary) Otitis media (duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of None

Was there an autopsy? ~~Yes~~ No

What test confirmed diagnosis? Physical examination

(Signed) Jos. A. Rosenbach, M. D.

1/23, 1930 (Address) 3018 Odonnell st, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 25 1930
UNDERTAKER D. Lowe Heeman	ADDRESS 922 Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 53288

CERTIFICATE OF DEATH

100 E 53288

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 18-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Braxton

(a) RESIDENCE NO. 905 Boyd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jos. Braxton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed JAN 23 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-21-30

17 I HEREBY CERTIFY, That I attended deceased from 8-8 1929 to 1-21 1930,
that I last saw him alive on 1-21 1930
and that death occurred, on the date stated above, at 1:20 m.

The CAUSE OF DEATH* was as follows:

Perineal urinary fistula
Urethral stricture

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. C. Lumpkin M. D.

1-22-1930 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Jan 24 1930
20 UNDERTAKER	ADDRESS
Wm. H. Chase & Son	14 E. Madison

Spec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53289

CERTIFICATE OF DEATH

90 E 53289

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 853 N. 35th St. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate E. Bullington

(a) RESIDENCE NO. 853 N. 35th St. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of George N. Bullington

6 DATE OF BIRTH (month, day, and year) March 28-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home Wd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Robert Tovell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Machin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Helen F. Hukes

(Address) 853 N. 35th St.

15 Filed JAN 23 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22-1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1925, to Jan 22, 1930, that I last saw her alive on Jan 22, 1930 and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis with hypertension

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) H. H. Onnold, M. D.

1/23, 1930 Address) 2429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Jan. 24-1930.

20 UNDERTAKER Horace F. L. Burgee — ADDRESS 3631 Fallsway

Spec.—2-29-28—L. F. S.—500 Bks.

E 53290

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 53290

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 730 4 E. Fuston ST., 8 WARD)

2—FULL NAME Andrew H. Morrow Jr

(a) RESIDENCE NO. 730 4 E. Fuston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Divorced

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20-1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic Railway

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co Md

PARENTS

10 NAME OF FATHER Andrew H. Morrow Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lola Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pennsylvania

14 Informant A. H. Morrow
(Address)

15 Filed 1930 By ADH

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 30

17 I HEREBY CERTIFY That I attended deceased from Sept 1, 1929, to Jan 22 1930, that I last saw h[illegible] alive on Jan 22 1930 and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. T. Rucker, M. D.

Jan 23 1930 (Address) 1301 4 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Wood Cemetery — DATE OF BURIAL: Jan 25 1930

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53291 — REGISTERED NO. 24 E 53291

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 N. Patterson Pk ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Schwarz

(a) RESIDENCE NO. 732 N. Patterson Pk ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Schwarz

6 DATE OF BIRTH (month, day, and year) Aug 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

-PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

11 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Schwarz

(Address) 732 N. Patterson Pk

15 Filed ..., 19.. C. HUMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 22 19 29 to Jan 22 19 30

that I last saw h... alive on Jan 22 19 30

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Cardiac Paralysis (duration) yrs. 1 mos. ds.

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Sauer M. D.

19 (Address) 801 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Jan 25 1930

ADDRESS

20 UNDERTAKER Frank Crowden 1906 E. Baltimore

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE

12-3-1930

Spec.—8-16-29—L. F. S.—100 Bks.

(Pazourek)

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 53292

CERTIFICATE OF DEATH

E 53292

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 315 S. Macon St. (ST.) 76-37 (WARD) 4

2—FULL NAME Peter Pazourek

(a) RESIDENCE NO. 315 S. Macon ST., WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Pazourek

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Railroad Yard Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Pazourek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Stella Pazourek

(Address) 315 S. Macon St.

15 C. HAMPSON JONES, M. D. Registrar

FEB 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Jan 22, 1930, that I last saw h im alive on Jan 20, 1930 and that death occurred, on the date stated above, at 1.45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Jan 25 1930

20 UNDERTAKER Thos Davidson 1906 Eastern Ave

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

E 53293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-2 53293

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2316 Fleet St. St. 1-3 WARD)

2-FULL NAME Mikolaj Olszewski

(a) RESIDENCE NO. 2316 Fleet St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Balbina Olszewski

6 DATE OF BIRTH (month, day, and year): Dec 10 1370

7 AGE: Years 59 Months 1 Days 10 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Paul Olszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Balbina Olszewski (Address) 2316 Fleet St.

15 Filed JAN 23 1930 19.. G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15. 1930, to Jan 20. 1930, that I last saw h[illegible] alive on Jan. 18. 1930, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteria-Sclerosis

(duration) Autumn yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) A. Flax, M. D.

Jan 20, 1930 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: Jan 24 1930

20 UNDERTAKER: John M. Weber ADDRESS: 401 S Chester

CAUSE OF DEATH must be plainly written, so that it may be properly classified. Each statement of cause TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53294 | 8001 | E 53294

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 719 N. Fremont St. (WARD) 17-23

2-FULL NAME Jeane Hopkins

(a) RESIDENCE NO. 719 N. Fremont St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eze. Hopkins

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE: 73 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Dan V. Hopkins
(Address): 719 N. Fremont Ave

15 Filed 2 3 1930, 19.....
C. HAMPSON JONES, M. D.
By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/21, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/21, 1930, to 1/21, 1930
that I last saw h alive on 1/21, 1930
and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Embolism of Coronary Artery

(Duration) Immediate yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension Heart Disease (Duration) yrs. 4 mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Eller, M. D.

1/24, 19.. (Address) 924 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn | DATE OF BURIAL: 1/24, 1930

20 UNDERTAKER: Samuel J. Beverly | ADDRESS: 57 W. Biddle

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53295

232256

Neuro. Surg.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 53205

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. JOHNS HOPKINS HOSPITAL ST. 16-7 WARD)

2—FULL NAME John Seifert

(a) RESIDENCE NO. 509 S. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret

6 DATE OF BIRTH (month, day, and year): Feb 23 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: iron-worker

(b) General nature of industry, business, or establishment in which employed (or employer): 079 unknown

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: August

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-22-30

17 I HEREBY CERTIFY, That I attended deceased from 12-18-, 1929, to 1-22-, 1930, that I last saw him alive on 1-22-, 1930 and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of the Stomach with metastases

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 7, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological Exam

(Signed) Clarence E. Gardner M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery

DATE OF BURIAL: Jan 25 1930

20 UNDERTAKER: George W. Zinkler

ADDRESS: 1737 E. Eager St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53296 E 53296

CERTIFICATE OF DEATH

7185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. ST. Joseph Hospital St., 9-17 Ward)

2-FULL NAME Mary Elizabeth Turner

(a) RESIDENCE NO. Whitehall, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13/1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	66	10	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Harford Co., Md.

PARENTS

10 NAME OF FATHER Wm. H. Hope

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Sarah E. Moore

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Harford Co., Md.

14 Informant Zirkler & Zirkler
(Address)

15 Filed 19 C. H. EMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injury to spinal cord.-Fracture of 5th & 6th cervical Vertebra. Accidently fell down stairs at her home Jan 20/30 ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)
(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. H. Empson Jones, M. D.

1/22/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys cem. Sykesville Md. — DATE OF BURIAL Jan 24 1930

20 UNDERTAKER E. G. Kurtz & Son per. G. W. Zirkler — ADDRESS Sarettsville Md.

2 B 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53297 E 53297

CERTIFICATE OF DEATH

84

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3027 Clifton Ave ST.) 15-67 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Seymour

(a) RESIDENCE NO. 3027 Clifton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

6 DATE OF BIRTH (month, day, and year) Dec 23-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John M. Seymour

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va

12 MAIDEN NAME OF MOTHER Lydia Ann Hottz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Seneca

14 Informant Mrs Sarah H. Reiter

(Address) 3027 Clifton Ave

15 Filed 2 3 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 18—, 1929, to Jan-23, 1930, that I last saw him alive on Nov. 20, 1929 and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris, with arteriosclerosis, and myocardial insufficiency.

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Acute Dilatation. —

(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. H. Seymour M. D.

1/23. 1930 (Address) 2202 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Western Cemetery

DATE OF BURIAL 1/25 1930

20 UNDERTAKER Chas E. Crane & Son

ADDRESS 1800 W. Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53208 E 53208

CERTIFICATE OF DEATH

1—PLACE OF DEATH Bon Secours Convent REGISTERED NO. 44

CITY OF BALTIMORE: (No. 2000 W. Baltimore ST. 10-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sister Justinian Manny

(a) RESIDENCE NO. 2000 W. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
75	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister Nun

(b) General nature of industry, business, or establishment in which employed (or employer) Bon Secours

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Convent Record (Address)

15 Filed 2 3 1930, 19 Registrar

C. F. JAMESON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/22/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 2, 1929, to 1/22, 1930, that I last saw h alive on 1/19, 1930 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Gastric hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? —

(Signed) Theo. E. Stacy Jr., M. D.

, 19 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 1/23/30

20 UNDERTAKER Engle & Farley Fulton & Fayette

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 53299

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 53299

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1027 Madison Ave ST. 1-24 WARD)

2—FULL NAME Baby Cubitt

(a) RESIDENCE NO. 1027 Madison Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	XXXXXXX

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of XXXXXXX

6 DATE OF BIRTH (month, day, and year) 14 hrs

7 AGE Jan. Years	Months	Days	If LESS than 1 day, [illegible] hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work XXXX

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Robert Cupitt

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Winnie Mason

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penn

14 Informant

(Address)

15 Filed JAN 23 1930, 19 1296 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19 30, to [illegible], 19 30,

that I last saw h[illegible] alive on [illegible], 19 30

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Congenital Atlectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1021 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL [illegible] 19

20 UNDERTAKER [illegible] Commissioner Health

ADDRESS

JAN 23 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 53300

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 53300

CERTIFICATE OF DEATH

REGISTERED NO. 58

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Arthur C. Gibson

(a) RESIDENCE NO. Peabody Apts. Balto, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 13 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Stella Ruffel

6 DATE OF BIRTH (month, day, and year) Feb. 9, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	9 11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sect.

(b) General nature of industry, business, or establishment in which employed (or employer) Jessup Co.

(c) Name of employer Safe Jessup Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER A. C. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Victoria Canna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. A. C. Gibson

(Address) Calvert and 30th Sts.

15 Filed JAN 23 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1930 to Jan. 22, 1930

that I last saw him alive on Jan. 22, 1930

and that death occurred, on the date stated above, at 1:05 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Probable Int. Hem.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No. What test confirmed diagnosis? Clinical Findings.

(Signed) A. R. Wilkerson, M. D.

, 19 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 1/25 1930

20 UNDERTAKER Henry W. Mears and Son

ADDRESS 805 N. Calvert

Spec.—8-16-29—L. F. S.—100 Bks.

2B 32923
2B 33301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

131

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Antonio Lombardo

(a) RESIDENCE NO. 1016 Stiles St ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaretta Lombardo

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer & Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Lombardo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 31 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan. 21, 1930, that I last saw h[illegible] alive on Jan 21, 1930, and that death occurred, on the date stated above, at 6 15 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Pyelonephritis
Anaemia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Hydropyonephrosis, Calculi. (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) A O Smith, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jan. 24, 1930.
20 UNDERTAKER Randall J Hoppe	ADDRESS 304 E Eden St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53302

CERTIFICATE OF DEATH

91-002 V

E 53302

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2—FULL NAME Catherine Kolenecz

(a) RESIDENCE NO. Preston & Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Koleniecz

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Koleniecz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.
JAN 23 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1930, to Jan 22 1930,
that I last saw h alive on Jan 22 1930
and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Senility
Arteriosclerosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema Lungs
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Benedict Ross M. D.
1/23. 1930 (Address) 1216 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Jan 24 1930

20 UNDERTAKER Rita Niedfeld

ADDRESS 914 Gremmel Ave

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53303 ✓ E 53303

CERTIFICATE OF DEATH

90

REGISTERED NO. 24

1—PLACE OF DEATH

CITY OF BALTIMORE; (No.) 829 Hamilton Terrace ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie M. Sprecklemyer

(a) RESIDENCE NO. 829 Hamilton Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68	—	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Geo. H Sprecklemyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adelaide Harmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Mrs) Adelaide A. Boyle (Address) 829 Hamilton Terrace

15 Filed 1 23 1930 G. HUMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 7, 1930, to Jany 22, 1930, that I last saw her alive on Jany 23, 1930, and that death occurred, on the date stated above, at 8.25 P. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelletiaux, M. D.

1/23, 1930 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Holy Redeemer Cem — DATE OF BURIAL Jan 25 1930

20 UNDERTAKER Harry Jenkins & Co — ADDRESS Edmondson Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 53304

E 53304

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 412 Venable Ave St. 12 Ward 19)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida R Davis

(a) RESIDENCE NO. 412 Venable Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced (or) WIFE of: Jerry

6 DATE OF BIRTH (month, day, and year): Feb 4th 1872

7 AGE: Years 57 + Months 11 Days 18 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: John C Gill

11 BIRTHPLACE OF FATHER (city or town): Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER: Rebecca Jones

13 BIRTHPLACE OF MOTHER (city or town): Balto Md

(State or country)

14 Informant: Mrs Mabel Seibel

(Address) 412 Venable Ave

15 Filed JAN 24 1930, 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to her death on the date stated above.

The CAUSE OF DEATH* was as follows:

Jobecular Disease of Heart

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

(Signed) John Morrissey M. D. (Coroner)

1930 (Address) 3C 32 Rolandvue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery Date of Burial 1/27/1930

20 UNDERTAKER: Wm Cook ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Very important. See instructions on back of certificate. FOR STATEMENT OF OCCUPATION IS

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

233009 Ward 53305

CERTIFICATE OF DEATH

E 53305

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. WARD) 14

2—FULL NAME Charles Ulrich

(a) RESIDENCE NO. 8 Arthur Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
Catonsville

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Irma

6 DATE OF BIRTH (month, day, and year): 1-16-77

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53 +2		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Minister

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Julius H.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

Filed APR 24 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-22-30

17 I HEREBY CERTIFY, That I attended deceased from 1-13-1930 to 1-22-1930

that I last saw h[illegible] alive on 1-22-1930

and that death occurred, on the date stated above, at 10 [illegible] a. m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis
Post-Operative Hemorrhage
Bronchopneumonia

(duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary) Benign prostatic hypertrophy (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-15-30

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) H. C. Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem Baltimore Md

DATE OF BURIAL: 1/25 1930

UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53306

CERTIFICATE OF DEATH

129

E 53306

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 78 S. Kossuth ST. 20-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry O. Holloway

(a) RESIDENCE NO. 78 S Kossuth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabelle H Holloway

6 DATE OF BIRTH (month, day, and year) Oct 12. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Orville A. Holloway (Address) 78 S Kossuth St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 19 29, to Jan 22, 19 30, that I last saw h alive on Jan 22, 19 30 and that death occurred, on the date stated above, at 2 55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) 6 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. P. Van Schaick M.D. M. D.

19 5 (Address) 534 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 1/27 1930

20 UNDERTAKER W. H. Cook

ADDRESS 1217 St Paul St

NOV 24 1930 FLEXNER JONES, M.D.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53307 — 9Y-08V — E 53307

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Southern Hospital ST. 42-50 WARD)

2-FULL NAME Nelson C. Waters.

(a) RESIDENCE NO. Southern Hospital ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male-	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
74	75	9	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer - Ret'd
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Somerset Co Md

PARENTS
10 NAME OF FATHER Wm E Waters
11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Co Md
12 MAIDEN NAME OF MOTHER Anna Baker
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Southern Hospital
(Address) Frank Waters

15 Filed JAN 24 1930 19 HAMPSON JONES M D Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to Jan. 22, 1930, that I last saw him alive on Jan. 21, 1930, and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

over 5 yrs. mos 1 da.
(duration)

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) H C Hess, M. D.
1-22 1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns Waverly — DATE OF BURIAL: Jan 24 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 N Bond St

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Ehardt.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53308 — CERTIFICATE OF DEATH — 119 — E 53308

1—PLACE OF DEATH Church Home & Infir. REGISTERED NO. 2248

CITY OF BALTIMORE: (No. Broadway & Fairmount WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Ehrandt

(a) RESIDENCE NO. 606 Nicall Ave. ST. Govans WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick C Ehardt

6 DATE OF BIRTH (month, day, and year): Apr. 21, 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
56 yrs.	9	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home 037
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS
10 NAME OF FATHER: Patrick McGarvey
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Mary Costello
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Husband
(Address): above

15 JAN 24 1930 — [illegible] JAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): ~~Apr. 21, 1930~~ Jan. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/16/30, 19..., to 1/22, 1930, that I last saw h[illegible] alive on Jan. 22 1930 and that death occurred, on the date stated above, at 9:55 P m.

The CAUSE OF DEATH* was as follows:
Diverticulitis of Sigmoid
Fecal Fistula
(duration) 1 yrs. mos. ds.
CONTRIBUTORY (Secondary) Peritonitis + Post Operative Shock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of Jan. 21, 1930
Was there an autopsy? No
What test confirmed diagnosis? Clinical & Operative
(Signed) Chas. B. Wallace, M.D.
, 19 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 1/25/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53309 135 E 53309

REGISTERED NO.

1—PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 12-51 ST. WARD)

2—FULL NAME Joseph P Sellers

(a) RESIDENCE NO. 2 - West 20th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Mary - E.

6 DATE OF BIRTH (month, day, and year): March 10/1844

7 AGE: Years 85 | Months 10 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Nathaniel Sellers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Peterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Joseph P Sellers

(Address): 2 - West 20th

15 Filed JAN 24 1930 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 23-1930

17 I HEREBY CERTIFY, That I attended deceased from January 17, 1930, to January 23, 1930, that I last saw him alive on January 23, 1930 and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Benign prostatic hypertrophy

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Jan 17-1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs and symptoms.

(Signed) Louis P. Hundley, M. D.

Jan 23 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Christ Church Cabaret Co

DATE OF BURIAL: 1/25 1930

20 UNDERTAKER: W M Crook

ADDRESS: 1291 S. Bond

Cor.—10-10-29—A Co.—100 Bks.

E 53310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 V

E 53310

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 838 Tyson St. 11-24 Ward)

2-FULL NAME Eda Tyson Fisby

(a) RESIDENCE NO. 838 Tyson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	71 44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER Chas Hawkins

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Lucy Caulfield
(Address) Atlantic City N.J.

15 Filed JAN 24 1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. B. Fuchs, M. D.

Jan 20th 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Jan 24 1930
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 N Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53311 | 57 | E 53311

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2060 E Hoffman ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence V. Stevens

(a) RESIDENCE NO. 2060 E Hoffman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Stevens

6 DATE OF BIRTH (month, day, and year) 2/2 1881

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Isaac Evens

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Bertha Hartz

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mr Charles Stevens
(Address) 2060 E Hoffman St

15 Filed JAN 24 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 23, 1930, that I last saw her alive on Jan 22, 1930 and that death occurred, on the date stated above, at 10:20 a. m.

The CAUSE OF DEATH* was as follows:

Hemaphlegia first Left & then Right

Diabetes & Myocarditis

(duration) yrs. mos. 7 ds. Hemiplegia

CONTRIBUTORY (Secondary) Diabetes & Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Chemical

(Signed) [illegible] Carman, M. D.

1-24-1930 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	1/25 1930
20 UNDERTAKER Albert L Hilliard	ADDRESS 1606 N Chester St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53312

CERTIFICATE OF DEATH

38 E 53312

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Joseph Hospital St. (Ward) 26-37

2-FULL NAME Maria De Berardinis

(a) RESIDENCE NO. 208 S. Haven St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be property classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pietro DeBerardinis

6 DATE OF BIRTH (month, day, and year) Mar 19/1902

7 AGE	Years	Months	Days	IF LESS (than 1 day ..... hrs. or ..... min.
	27	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Neir

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Pasqualina DeEmedio

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Pietro DeBerardinis
(Address) 208 S. Haven St

15 Filed JAN 24 1930 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Accident- Tertiary Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital Record

(Signed) [signature], M. D.

1/24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cemetery

DATE OF BURIAL 1 25 1930

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53313

CERTIFICATE OF DEATH

425-181-001

E 53313

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 665 W. Fayette St., 425 Ward)

2-FULL NAME Joseph Root

(a) RESIDENCE NO. 665 W. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plasterer's Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Joseph Root

11 BIRTHPLACE OF FATHER (city or town) U.S.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Rymar

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) U.S.

14 Informant Miss Mildred Clemens Root
(Address) Scranton, Pa.

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Poisoned by Carbon Monoxide (Illuminating Gas). Probably Accidental Death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

1/23, 1930 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 25 1930
20 UNDERTAKER Joseph D Cook	ADDRESS 1003 W Lake

IF DEATH IS IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/ E 53314

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 14 54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Brown

(a) RESIDENCE NO. 544 Baker st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
18	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Nellie Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JAN 24 1930 H. HARRISON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1929, to Jan. 23, 1930,

that I last saw h. alive on Jan. 23, 1930

and that death occurred, on the date stated above, at 3.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. G. Arnold Jr. M. D.

1-23 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Jan 27 1930

20 UNDERTAKER Franklin W Seitz

ADDRESS 709 W 33 St

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53315 3/ E 53315

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Bradford ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Miton

(a) RESIDENCE NO. 1119 Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Joseph Miton

6 DATE OF BIRTH (month, day, and year) Aug 19-1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Walter Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Joseph Miton

(Address) 1119 N. Bradford St

15 Filed 10 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from December 29, 1930, to January 22, 1930, that I last saw h e alive on January 22, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J Syd, M. D.

Jan 24, 1930 (Address) 2065 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Jan 28 1930

20 UNDERTAKER Chas C. Fuller & Son — ADDRESS 2334 Jefferson St

Spec.—8-16-29—L. F. S.—100 Bks.

Lantz

E 53316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 57 ✓

E 53316

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., W 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Lantz

(a) RESIDENCE NO. New Windsor Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Diger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Adkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Earl Lantz

(Address) New Windsor

15 Filed JAN 24 1930 H. [illegible] JONES M. Registrar

Post

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23rd 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 12th, 1930, to Jan 23rd, 1930, that I last saw h[illegible] alive on Jan 23rd 1930 and that death occurred, on the date stated above, at 7 00 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Post of urine etc

(Signed) Lewis P. Lantz, M. D.

Jan 24th 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hunters	Jan 26 1930
20 UNDERTAKER	ADDRESS
L. H. Weimer	New Windsor

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 | E 53317

REGISTERED NO. E 53317

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 Lor ST. 5-8 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.) 1/30/30

2—FULL NAME Mary Lee Perry alsh known as Mary Willis R.F. Young

(a) RESIDENCE NO. 1138 Lor ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Perry

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER John McKee

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Emma Harris

13 BIRTHPLACE OF MOTHER (city or town) (State nr country) N. C

14 Informant Emma McKee

(Address) 1138 Lor St

15 1-24-1930 H. W. [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Jan 22, 1930, that I last saw h e alive on Jan 21, 1930 and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows: Pulmonary Phthisis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

1/26, 1930 (Address) 14 m Edmonson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 1-25 1930

20 UNDERTAKER Byron & Wright

ADDRESS 1218 Mc Calderry St

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53318

CERTIFICATE OF DEATH.

10 1001 E 53318

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Agnes Hospital 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. William Tuck

(a) RESIDENCE NO. 1529 Light ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Divorced

6 DATE OF BIRTH (month, day, and year): May 14 - 1882

7 AGE: Years 47 Months 8 Days 8 If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: R. J. Tuck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Salena Stilwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Richard Tuck (Address): 1542 Fulton

15 Filed .... 19 .... Registrar

24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-22 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-21 .1930. to 1-22 .1930 that I last saw h[im/er] alive on 1-22 .1930, and that death occurred, on the date stated above, at 5.50 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia - lower lobes both lungs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George Brunner, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: 1/24 1930

20 UNDERTAKER: J. F. McCully

ADDRESS: 1306 E. Fort

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53319 ✓ 161-001

CERTIFICATE OF DEATH

E 53319

1—PLACE OF DEATH Woman's Hospital REGISTERED NO. 27-48

CITY OF BALTIMORE: (No. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Premature VanNess

(a) RESIDENCE NO. 425 Lake Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan. 23, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, 19 hrs. or 47 min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Arthur Gordon VanNess

11 BIRTHPLACE OF FATHER (city or town) Athens (State or country) Pa.

12 MAIDEN NAME OF MOTHER Kathryn Watson

13 BIRTHPLACE OF MOTHER (city or town) Minneapolis (State or country) Minn.

14 Informant Mr. Arthur VanNess
(Address) 425 Lake Ave.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-30.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1930, to Jan. 24, 1930, that I last saw her alive on Jan. 24, 1930 and that death occurred, on the date stated above, at 7:55 A.m.

The CAUSE OF DEATH* was as follows:

Premature 8 mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John M Bergland, M. D.

, 19 (Address) 10 W St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Jan. 27 1930

20 UNDERTAKER Jno. T. Ruckert Sons ADDRESS Lorch Pa

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53320

CERTIFICATE OF DEATH

E 53320

REGISTERED NO. 10108 53320

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 117 W. Barre St. 27-30 Ward)

2-FULL NAME John E. Langley.

(a) RESIDENCE NO. 117 W. Barre St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, HUSBAND of Rose E. Langley.

6 DATE OF BIRTH (month, day, and year) April 14, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	57	9	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cooper.
(b) General nature of industry, business, or establishment in which employed (or employer): 015
(c) Name of employer

9 BIRTHPLACE (city or town) Charles Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Rose E. Langley. (wife)
(Address) 117 W. Barre St.

15 Filed ... 193... Registrar

APR 4 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Eisenhardt, M. D.

1/28. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem. Co.	Jan 26 1930
20 UNDERTAKER	ADDRESS
Fred or J. Dausenson	703 Hanover

IMPORTANT—In order that there may be no delay in the burial of the dead, the Registrar of Vital Statistics will issue a permit for burial only when this certificate is properly filled out. Each statement of fact and of OPINION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E-53321

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-E 53321

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ~~Moody~~ Holden Moody

(a) RESIDENCE NO. 1104 Carson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffuer

(b) General nature of industry, business, or establishment in which employed (or employer) Of

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Anderson Holden

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Susan ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JAN 24 1930, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22-30

17 I HEREBY CERTIFY, That I attended deceased from 12-20-29, 19..., to 1-22-30, 19...,

that I last saw him alive on 1-22-30, 19...

and that death occurred, on the date stated above, at 8:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Toxic

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypertension? (over)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren M. McClean, M. D.

1-23, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

20 UNDERTAKER Dennett Eastes

DATE OF BURIAL 1-24 1930

ADDRESS 716 Pa ave

Cor.—10-10-29—A Co.—100 Bks.

E 53322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

181-001 E 53322

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 665 W. Fayette St. 17-25 Ward)

2-FULL NAME Edwin J. Morrow

(a) RESIDENCE NO. 665 W. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carolyn Morrow

6 DATE OF BIRTH (month, day, and year) Feb 6 - 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	32	11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter 050
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER William Morrow

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Herma Fischer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Carolyn Morrow
(Address) 1735 N. Fulton Ave.

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE-OF DEATH* was as follows:
Poisoned by carbon monoxide. (Illuminating Gas) Probably Accidental Death
(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fuller M. D.

1/23. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem.	1-24-30
20 UNDERTAKER Daniel Easton	ADDRESS 916 E. Lanvale

IMPORTANT. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

King

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53323

CERTIFICATE OF DEATH

84 ✓ E 53323

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 Mt. Royal Ave. ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura A. King

(a) RESIDENCE NO. 1509 Mt. Royal Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. King

6 DATE OF BIRTH (month, day, and year) July 27, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, (State or country) Md.

PARENTS

10 NAME OF FATHER John R. Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Waller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. George W. King

(Address) 607 W. 40th St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan 22, 1930, that I last saw her alive on Jan 22, 1930 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) John S. Richey M. D.

19 (Address) 12 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Jan. 25, 19 30

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Spec.—1-10-21—M&T—1500 Bks.

R 53324

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

40 E 53324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) 15-56 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Yetta Kositzky

(a) RESIDENCE NO. Levindale Home (St.) (Reg #2839 State Asylum) (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white Indian

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Morris Kositzky 185 N

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 78 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: old age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Anton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Anton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Leurs 1439 Eastern Ave

15 Filed JAN 24 1930 H. L. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/22 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/19, 1930, to 1/22, 1930, that I last saw her alive on 1/22, 1930, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

interstitial carditis — mitral stenosis. & chronic myocarditis

(duration) 1 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Physical Exam

(Signed) A. A. Silver, M. D.

1/22, 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrer Rosedale Cem

DATE OF BURIAL: 1/24 1930

20 UNDERTAKER: Jack Leurs 1439 Eastern Ave

ADDRESS

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 74001 ✓

E 53325

E 53325

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 14-20 Ward)

2-FULL NAME Estella Godsey

(a) RESIDENCE 807 Eutaw St Spencer Pent. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Landon Godsey

6 DATE OF BIRTH (month, day, and year) May 15 1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	8	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Isaac Godsey

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Lucie Owings

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Landon Godsey
(Address) 807 E Eutaw St

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorragic Meningitis

(duration) ... yrs. ... mos. 3 hours

CONTRIBUTORY (Secondary) Cerebral

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Examination

(Signed) Carlton Smith, M. D.

Jan 22/1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pt Reynolds Va	Jan 24 1930
20 UNDERTAKER Wm. R. G. Elliott	ADDRESS 1720 Ashland Ave

IMPORTANT—Fill in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

JAN 24 1930

Cor.—10-10-29—A Co.—100 Bks.

E 53326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

166 E 53326

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St., 17-24 Ward)

2-FULL NAME Elnor Blanks Bolden

(a) RESIDENCE NO. 511 Greenwillow St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Bolden

6 DATE OF BIRTH (month, day, and year) Dec 18- 1903

7 AGE	Years	Months	Days 4	IF LESS than 1 day ..... hrs. or ..... min.
	26	1	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic.
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER James Blanks

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Douglas

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Ira Blanks
(Address) 1720 N 21st

15 Filed JAN 24 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy on (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy & Inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Gastro Enteritis

b Suicide (duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Ovr dose Bichlride of Mercury (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Regulary

(Signed) H. C. Hunt, M. D.

Jan 22 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Jan. 27 1930

20 UNDERTAKER Mrs R. A. Elliott — ADDRESS 1725 Eastlander

IMPORTANT. See instructions on back of certificate. Fill out in plain terms, so that it may be properly classified. Each statement of occurrence is very

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53327 + 24 E 53327

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 945 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Myrtle C. Caskey

(a) RESIDENCE NO. Martinsburg, West Va. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Non Resident yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Claude O. Caskey

6 DATE OF BIRTH (month, day, and year) March 14, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Geo. J. Castle

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va.

12 MAIDEN NAME OF MOTHER Alice Andrews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Roma

14 Informant Claude O Caskey

(Address) Martinsburg West Va.

15 JAN 24 1930 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 23, 1930, that I last saw h[illegible] alive on Jan 23, 1930 and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

probably meningococcic

(duration) ....yrs. ....mos. ? ....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Refused

What test confirmed diagnosis? Spinal Puncture

(Signed) Myron B Hill, M. D.

1/24, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg W Va

DATE OF BURIAL Jan 24 1930

UNDERTAKER W M Routson

ADDRESS 223 S Howard

Spec.—1-12-33—M&T—500 Claudie Calounds Evans.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53328 101-001 E 53328

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 404 N. Carolina St. WARD 5-9

2-FULL NAME Calounds Evans

(a) RESIDENCE NO. 404 N. Caroline St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	24	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer Central Foundry

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Henry Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dassie Worden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Norell Brehan

(Address) 2232 Bud St Apt a

15 Filed 2 4 1930, 19 Pell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 1 · 23 1930

17 I HEREBY CERTIFY, That I attended deceased from 1 · 20 · , 1930 , to 1 · 23 · , 1930 ,

that I last saw h — alive on 1 · 23 , 1930 ,

and that death occurred, on the date stated above, at 12:45 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) William Lloyd Penny, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Smithfield Va DATE OF BURIAL Jan 29 1930

20 UNDERTAKER Robert S. Williams ADDRESS 1515 N. Caroline St

Spec.—8-16-29—L. F. S.—100 Blks.

E. 53329.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 53329 + 132 E. 53329

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 4-30 S. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Sapp.

(a) RESIDENCE NO. Goldsborough ST., Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Md~~ Dela. (State or country)

PARENTS

10 NAME OF FATHER Elijah Sapp

11 BIRTHPLACE OF FATHER (city or town) Dela (State or country)

12 MAIDEN NAME OF MOTHER Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harrington Del

14 Informant M K Hennessee (Address) Denton Md

15 Filed 2 4 1930 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23-1930.

17 I HEREBY CERTIFY, That I attended deceased from December 20, 1929, to January 23, 1930, that I last saw h[illegible] alive on January 23, 1930 and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronco pneumonia typhoid by, Acute Colecystitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 21-1929

Was there an autopsy? No.

What test confirmed diagnosis? Clinical signs + symptoms.

(Signed) Samuel D Broken, M. D.

1930 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Denton Md

DATE OF BURIAL 1-26-1930

20 UNDERTAKER Harry N. Armacost

ADDRESS 4704 Edgewood Ave.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53330 — 90 — E 53330

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital ST. 11-15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. Charles O'Donovan

(a) RESIDENCE NO. 5 E. Read ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Lifetime How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Shriver O'Donovan

6 DATE OF BIRTH (month, day, and year) Feb 7-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 654

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles O'Donovan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Henrietta Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Rose Shriver O'Donovan (Address) 5 E. Read St.

15 Filed JAN 24 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24/30

17 I HEREBY CERTIFY, That I attended deceased from 1/16/30, to 1/24/30, that I last saw h alive on 1/23/30 and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (or embolism)

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary) Hypertensive cardio vascular disease (duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Geo. E. Stacy Jr. M. D.

19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Jan 25 1930

20 UNDERTAKER Chas. P. Ward Son ADDRESS 1100 W. Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53331 — 15-001 — E 53331

REGISTERED NO. 15-68

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2792 W North Ave ST., (15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dallie H Caple

(a) RESIDENCE NO. 2792 W North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed, or Divorced, (write the word)~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm D. Caple

6 DATE OF BIRTH (month, day, and year) July 31 1854

7 AGE Years 75 Months 5 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Kitzman

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Lydia Emmart

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Wm D Caple (Address) 2792 W North Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 14 1930 to Jan 24 1930 that I last saw h alive on Jan 23 1930 and that death occurred, on the date stated above, at 2 45 m.

The CAUSE OF DEATH* was as follows: Hemiplegia and Paralysis

Oedema of Lungs

(duration) yrs. 10 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A K Plumb M. D.

19 (Address) 1734 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Jan 27 1930

20 UNDERTAKER Peters & Doe ADDRESS 1723 N Fayette

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53332

CERTIFICATE OF DEATH

60-002 E 53332

REGISTERED NO. 15-60

1-PLACE OF DEATH Md General Hosp.

City of BALTIMORE: (No. Howard & Madison St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence E Jordan

(a) RESIDENCE NO. 2010 Hinkelmond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jordan

6 DATE OF BIRTH (month, day, and year) July 18, 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	47	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paster 086

(b) General nature of industry, business, or establishment in which employed (or employer) Paper

(c) Name of employer Geo Frankel & Sons

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER William Jordan

11 BIRTHPLACE OF FATHER (City or town) Dayton

(State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Preston

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Hosp Record

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929 to Jan 24, 1930

that I last saw him alive on Jan 24, 1930

and that death occurred, on the date stated above, at 8 41 a m

The CAUSE OF DEATH* was as follows:

Toxic Adenoma Thyroid

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Toxic Psychosis

(duration) yrs. mos. 30 da.

18 Where was disease contracted

if not at place of death? ✓

Did an operation precede death? Yes Date of Jan 21, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. K. Mansfield, M. D.

1/24, 1930 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial Jan 27 1930

20 UNDERTAKER Bertram Fore ADDRESS 1123 N Fayette

Fore

JAN 24 1930 C. HAMPSON JONES, M. D.

very important. See instructions on back of certificates.

OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION IS

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53333

CERTIFICATE OF DEATH

38 E 53333

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 407 N. Durham St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Waters C.

(a) RESIDENCE NO. 407 N. Durham St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Waters

6 DATE OF BIRTH (month, day, and year) May 30 / 1888

7 AGE 41 Years Months Days 22 — 42 y-8-22

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer In own family

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Samuel Spence

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (City or town) Balto

(State or country) Md

14 Informant Isaac Waters

(Address) 407 N. Durham St

Filed ..... 19 .....

Registrar

2 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Jan 22 / 1930

17 I HEREBY CERTIFY, That I attended deceased from

Jan 21, 1930, to Jan 22, 1930.

that I last saw h[illegible] alive on Jan 21, 1930.

and that death occurred, on the date stated above, at 730 P.m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Hemiplegia

24 (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pernicious Intermittent Nephritis (duration) 6 yrs. mos. da.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard I Eastman, M. D.

. 19 (Address) 1514 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

Date of Burial Jan 25 1930

20 UNDERTAKER Theodore C White

ADDRESS 1130 Hughes

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53334 E 53334

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital ST. ..... WARD)

2-FULL NAME Mrs. Albert C. Schultz

(a) RESIDENCE NO. 2102 W. Pratt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 41 yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Margaret C. Schultz.

6 DATE OF BIRTH (month, day, and year) March 18-1877.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
52	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant Proprietor Out

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Schultz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Henerette Haase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Margaret C. Schultz. (Address) 2102 W. Pratt St.

15 JAN 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 22, 1930, that I last saw h~~im~~ alive on Jan 22, 1930 and that death occurred, on the date stated above, at 12.45 p. m

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 7 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) 0 yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. H. Carnegie, M. D.

, 19 ✓ (Address) W. Balto. Md. 6-30.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. — DATE OF BURIAL Jan. 25 - 1930.

20 UNDERTAKER Charles J. Schwab. ADDRESS 505 N. Monroe St.

FROM IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Bks.

Michelina Sala

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53335

CERTIFICATE OF DEATH

90 E 53335

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 E. Montgomery ST. 12-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michela Sala

(a) RESIDENCE NO. 13 E. Montgomery ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Carlo Sala

6 DATE OF BIRTH (month, day, and year) Nov 16, 1869

7 AGE	Years	Months 2	Days 6	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Frank Larosa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Jenny Bevilacqua

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary Sala

(Address) 13 E. Montgomery

15 Filed 2 4 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22-30

17 I HEREBY CERTIFY, That I attended deceased from 1-1-, 1930, to 1-21, 1930

that I last saw her alive on 1-21-, 1930

and that death occurred, on the date stated above, at 1230 P.M.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis with hypertension + valvular heart trouble —

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) acute cardiac dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? clinical.

(Signed) E. J. Lucas, M. D.

1-24 1930 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Jan 27 1930

20 UNDERTAKER Frank V. Likitone

ADDRESS 2 S 1 E. Baltimore

Spec.—2-29-28—L. P. S.—800 Bks.

King

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53336

CERTIFICATE OF DEATH

44 E 53336

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1839 S. Charles ST. 1219 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susie E. King.

(a) RESIDENCE NO. 1839 S. Charles ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40. 5 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Middleton L. King.

6 DATE OF BIRTH (month, day, and year) July 26 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48,	5.	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co., Md.
(State or country)

PARENTS

10 NAME OF FATHER James E. Hendricks.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Ridgely

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Middleton L. King.
(Address) 1839 S. Charles St.

15 Filed 1-24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1. 21. 30

17 I HEREBY CERTIFY, That I attended deceased from 11. 28, 1928, to 1. 21. 1930

that I last saw her alive on 1. 21 1930

and that death occurred, on the date stated above, at 11.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What tests confirmed diagnosis? Physical Examination & Labor-atory examination

(Signed) Edward Norris M. D.

1.24, 1930 (Address) 107 East West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk Cem	Jan 26, 1930

20 UNDERTAKER C. Edward Evans ADDRESS 35 E Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53337 CERTIFICATE OF DEATH X 135 E 53337

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Reed Strause

(a) RESIDENCE NO. 516½ Baltimore ST., WARD Hanover, Pa. (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman 066
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania
(State or country)

PARENTS

10 NAME OF FATHER Elias Strause

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Magdalene Sumer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant W. F. Strause
(Address) Hanover Pa

15 Filed 2 4 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1930 to Jan. 24, 1930
that I last saw h[illegible] alive on Jan. 24, 1930
and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:
Benign Prostatic Hypertrophy

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pulmonary Embolus
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination

(Signed) Charles E. Cunningham M. D.
. 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hanover Pa
DATE OF BURIAL Jan 27 19 30

20 UNDERTAKER Geo E Thomas
ADDRESS Hanover Pa

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53338 100-001 E 53339

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 21 S. Calhoun St. Ward 19-24

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME G. Ernest Bantz

(a) RESIDENCE No. 21 S. Calhoun St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year): July 7, 1844

7 AGE — Years: 85 — Months: 6 — Days: 15 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa

14 Informant (Address) Louise Sase 21 S. Calhoun St

Filed JAN 24 1930 C. HEMPSON JONES, M. D. Registrar

By ..... Pct. .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jany 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 4, 1922, to Jany 22, 1930, that I last saw him alive on Jany 22, 1930, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) ..... yrs. ..... mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) M. A. O'Neill M. D.

1/23, 1930 (Address) 108 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Frederick Md — DATE OF BURIAL: Jan 25 1930

20 UNDERTAKER George J. Smith — ADDRESS 53 L Baltimore

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53339 31 E 53339

CERTIFICATE OF DEATH

REGISTERED NO. 0863

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mrs Hopkins Retreat ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Boesen

(a) RESIDENCE NO. Mrs Hopkins Retreat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 1 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Sept 21 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer): Sisters

(c) Name of employer: Convent

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: James Boesen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kurlingen Germany

12 MAIDEN NAME OF MOTHER: Anna M. Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Osby Germany

14 Informant: Mrs Hopkins Nurses

(Address): Mrs Hopkins Retreat

15 Filed 2-4 1930, 19 C. Hampson Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1925, to Jan 22, 1930, that I last saw h.. alive on Jan 22, 1930 and that death occurred, on the date stated above, at 11.10 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) 9 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Milton P. Hill, M. D.

19 (Address) Mrs Hopkins Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Amityville - Long Island N.Y.	Jan 25 1930
20 UNDERTAKER: Stewart Mercer Company	ADDRESS: Balto.

Spec.—2-29-28—1. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53340 91-002 E 53340

CERTIFICATE OF DEATH

REGISTERED NO. 14-20

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1421 Mt. Royal Avenue ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ann Cushing

(a) RESIDENCE NO. 1421 Mt. Royal Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 91 yrs. 1 mos. 20 ds. How long in U. S., if foreign birth? 91 yrs. 1 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): December, 3, ~~1840~~ 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	91	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Joseph Cushing, Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Ann Mackensie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Mrs. Josephine C. Morris (niece)

(Address) 708 Park Avenue

15 Filed 4 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan/23/30.

17 I HEREBY CERTIFY, That I attended deceased from Nov 16 1927, to Jan 23 1930,

that I last saw her alive on Jan 22 1930

and that death occurred, on the date stated above, at 10.20 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... moo. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. McCosker, M. D.

1/23/, 1930 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Jan-25-30 19

20 UNDERTAKER: STEWART & MOTHER COMPANY (WILLIAM J. WOODEN, Successor) — ADDRESS: 106 W. NORTH AVE.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53341 ✓ E 53341 90

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 20-69 ST., WARD)

2—FULL NAME John P. Gross

(a) RESIDENCE NO. 2524 Boyd St. ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	?		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 2 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-30

17 I HEREBY CERTIFY, That I attended deceased from 1-2-30, 19..., to 1-24-30, 19..., that I last saw him alive on 1-24-30, 19..., and that death occurred, on the date stated above, at 10:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic ? acute ?

(duration) ? yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypertension ? Arteriosclerosis

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

1-24, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 1/27/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

Dr. Hocking 1708 Park Road Epworth Govans Presby Church 21st 0037

E 53342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 11-0021

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 337 Rosebank Ave ST. Paul (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary O. Matthews

(a) RESIDENCE NO. 337 Rosebank Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Eli Allen Matthews

6 DATE OF BIRTH (month, day, and year): July 8th 1854

7 AGE: Years 75 | Months 6 | Days 14 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Esther L. Matthews

(Address) 337 Rosebank Ave

15 1 4 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/18, 1930, to 1/22, 1930, that I last saw h[er] alive on 1/22, 1930, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Influenza (duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary) Anaemia (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. C. Hocking M. D.

19 (Address) 6835 Yorkwood

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gunpowder Friends Meeting House Cemetery

DATE OF BURIAL: 1/25/1930

ADDRESS

20 UNDERTAKER: Wm Cook 1217 St Paul St

Spec.—6-16-29—L. F. S.—100 Blks.

D. Smith 4506 Harford Rd — Hom 0220

E 53343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓ E 53343

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 4506 Harford Rd St. 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Greene

(a) RESIDENCE NO. 4506 Harford Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Samuel S. Greene

6 DATE OF BIRTH (month, day, and year) March 10th 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home 0?

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Rapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Hommig

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Samuel S Greene

(Address) 4506 Harford Rd

15 Filed 2 4 1930 C. H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1930, to Jan 23 1930, that I last saw h alive on Jan 23 1930 and that death occurred, on the date stated above, at 9 30 P. M.

The CAUSE OF DEATH* was as follows:

Hem Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Phlebitis of Rt Femoral (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clara Smith, M. D.

1/27 1930 (Address) 4206 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	1/27/1930
UNDERTAKER Wm Cook	ADDRESS St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53344 90 E 53344

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 N. Milton Ave ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. Lenhenn

(a) RESIDENCE NO. 1824 N. Milton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Lenhenn

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gettysburg Pa.

PARENTS

10 NAME OF FATHER John Stapleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Gettysburg Pa.

12 MAIDEN NAME OF MOTHER Mary Landon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gettysburg Pa.

14 Informant William Lenhenn

(Address) 1824 N. Milton Ave

15 Filed 2 4 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23-1930

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1928 to January 23 1930.

that I last saw her alive on January 23, 1930

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Arterial Hypertension

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Abell King, M. D.

1-24, 19 (Address) 2027 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem Jan	27 1930
20 UNDERTAKER	ADDRESS
John C. Miller 243	E Lanvale

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53345 — CERTIFICATE OF DEATH × — 185 E 53345 — REGISTERED NO. 53345

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hamy Harris

(a) RESIDENCE NO. Finksburg, Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowrr

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Harris

6 DATE OF BIRTH (month, day, and year) Jan 16-1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48		8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER — Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Wm. T. Harris
(Address) Reisterstown, Md.

15 Filed ..... 19.. C. HUMPHREYS JONES, M. D. Registrar
JAN 1930 RBH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull
Accidental Death

(duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Finksburg, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zollyer, M. D.

1/24, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Prov. Lawn Cemetery Reg. No. 25 — DATE OF BURIAL Jan 26 1930

20 UNDERTAKER J. F. Elliott & Son — ADDRESS Reisterstown Md

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53346 E 53346 101-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 N. Carey ST.) 18-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Jubilee

(a) RESIDENCE NO. 317 N. Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Airey Jubilee

6 DATE OF BIRTH (month, day, and year) June 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Jubilee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Louisa Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Airey Jubilee

(Address) 317 N. Carey St

15 Jan 5 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Jan 22, 1930, that I last saw him alive on Jan 22, 1930 and that death occurred, on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows: Pneumonia Acute

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) A. B. Thomas M. D.

Jan 24 1930 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvery

DATE OF BURIAL Jan 25 1930

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Hemmd Hill

Spec.—2-29-28—L. F. S.—500 Bks.

E 53347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 53347

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Decatur St. ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia " " (Smalsky)

(a) RESIDENCE NO. 1435 Decatur St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Smalsky

6 DATE OF BIRTH (month, day, and year) Aug. 27 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Benjamin Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER McCracon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Francis Majewski

(Address) 1313 Cookes St

15 Filed 1-25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 23. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1930 to Jan 23rd 1930

that I last saw h[illegible] alive on Jan 22 1930

and that death occurred, on the date stated above, at 12 50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 days

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. 3 days

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Symp.

(Signed) Thos F. O'Herron, M. D.

1/27 1930 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem

DATE OF BURIAL 1/27 1930

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun & Hollins Sts

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53348 90 E 53348

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore; (No. 192 St Paul St. 12-19 Ward)

2-FULL NAME William J Keating

(a) RESIDENCE NO. 192 St Paul St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62	6	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N Y

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Wm J Keating
(Address) 192 St Paul

THOMPSON JONES, M.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Edocarditis Reserve of Heart

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1/25 1930 (Address) 3622 Roland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rudgewood N J	Jan 26 1930
20 UNDERTAKER George J Smith	ADDRESS 532 Hollins

Important. See instructions on back of certificate.

25 1930 [illegible] Registrar

G W SHOP HOSPITAL

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53349

CERTIFICATE OF DEATH

74001 E 53349

1-PLACE OF DEATH

City of Baltimore: (No. 647 Sarah Ann St., 7-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John D. Young

(a) RESIDENCE NO. 1535 McElderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Young

6 DATE OF BIRTH (month, day, and year) March 16 - 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	50	10	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) O.D.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Young

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Jackson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Alice Richardson (Sister)
(Address) 1535 McElderry St

15 Filed ....., 19.. C. HAMPSON JONES, Registrar.
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Coroner Gilpin, M. D.

1/27. 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Cemetery	Jan 26 1930
20 UNDERTAKER	ADDRESS
Chas. E. Johnson	446 N. Carrollton Ave

important. See instructions on back of certificate.

5 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53350

CERTIFICATE OF DEATH

54-002

REGISTERED NO. E 53350

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 15 N Bruce St. (Ward) 19-27

2-FULL NAME Baby Epps

(a) RESIDENCE NO. 15 N Bruce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) January 17, 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
			7 6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Epps

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Cora Bailey

13 BIRTHPLACE OF MOTHER (city or town) Newportnews
(State or country) Va

14 Informant Cora Epps
(Address) 15 N Bruce

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23 1930

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Due

(duration) ... yrs. ... mos. 1 da.

CONTRIBUTORY (Secondary) Broken Compression

(duration) ... yrs. ... mos. — da.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What tests confirmed diagnosis? By Inquest

(Signed) J C Grady, M. D.

19 (Address) 430 Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	Jan 28 1930
20 UNDERTAKER	ADDRESS
Joseph A Lisby	402 N Mount St

important. See instructions on back of certificate.

25 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53351 31 ✓ E 53351

CERTIFICATE OF DEATH

REGISTERED NO. 12-50

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2500 Guilford Ave ST. ..... WARD)

2—FULL NAME Lida T. Busick

(a) RESIDENCE NO. 2500 Guilford Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Busick

6 DATE OF BIRTH (month, day, and year) Sept. 10-1851

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Robt. T. Diggs

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Eliza A. Smith

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant John T. Busick
(Address) 2500 Guilford Ave

15 Filed ....., 19 ..... Registrar

C. HERBERT JONES, M. D.
25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Jan 23, 1930, that I last saw h.. alive on Jan 22, 1930 and that death occurred, on the date stated above, at 10-45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....

.....

antecedent ..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY Cardiac Failure
(Secondary)

Unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. H. Bruton, M. D.

, 19 (Address) 98 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Jan 25 1930
20 UNDERTAKER Chas. E. Franck	ADDRESS 802 Madison Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 53352

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901 E 53352

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 Mosher St., H-20 AR...)

2—FULL NAME John C De Shields

(a) RESIDENCE NO. 636 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) June 22-1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Joseph DeShields

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Pemilla Morton

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Pemilla Morton (Address) 636 Mosher St.

15 Filed JAN 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23.1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Jan 23, 1930, that I last saw h, alive on Jan 22, 1930 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Physical

(Signed) Wm H Wright, M. D.

1/29/30 (Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Charles Randallstown	Jan 26 1930

20 UNDERTAKER Virginia E Brooks ADDRESS 463 N. Carey St

Spec.—8-16-29—L. F. S.—100 Bks.

EMILE

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53353 #6 ✓ E 53353

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO. 12-19

CITY OF BALTIMORE: (No. ST 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Renty

(a) RESIDENCE NO. 2006 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 1880?

7 AGE: Years 49 50 (9) Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: J. F. Renty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary A. Sheppard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Record

(Address): Mercy Hosp.

15 Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/24/30

17

I HEREBY CERTIFY, That I attended deceased from 11-2, 1929, to 1-24, 1930,

that I last saw h alive on 1-24, 1930

and that death occurred, on the date stated above, at 10 55 m.

The CAUSE OF DEATH* was as follows:

Carcinoma uterus

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis CV dis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of about 6 mo ago

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Operative

(Signed) J Feyko, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem

DATE OF BURIAL: Jan 27 1930

20 UNDERTAKER: Henry W Jenkins Son

ADDRESS: N Carey & Orchard Sts

Spec.—1-30—M. & T.—250 Blks.

E 53354 HEALTH DEPARTMENT—CITY OF BALTIMORE E/53354

CERTIFICATE OF DEATH. 90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 Chester Oak ave ST. 27-48 WARD

2-FULL NAME Jacie Morris Wilhelm

(a) RESIDENCE NO. 421 Chester Oak Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — da. — How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Daniel S Wilhelm

6 DATE OF BIRTH (month, day, and year) August 8, 1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Harford County (State or country) Maryland

PARENTS

10 NAME OF FATHER Ed. N. Morris

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Taylor

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Maryland

14 Informant Mrs. H. C. Bickel (Address) 320 Southway Baltimore

15 Filed 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27/30

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to Jan 27, 1930, that I last saw her alive on Jan 27, 1930, and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. 6 mos. ..... da.

CONTRIBUTORY (Secondary) Aortic Stenosis, Mitral insufficiency (duration) ..... yrs. 6 mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm. C. Stephens, M. D.

1/27. 1930 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Grove, Cemetery. DATE OF BURIAL Jan. 26 1930

20 UNDERTAKER Wm. C. Brooks & Son ADDRESS Govans

Spec.—2-29-28—I. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53355 — 38 — E 53355

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 W. Cross ST. ~~23-31~~ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Lee

(a) RESIDENCE NO. 32 W Cross ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
49	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) If

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ella Blake Ford

(Address) 32 W Cross

15 Filed 2 5 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/24/30

17 I HEREBY CERTIFY, That I attended deceased (from 12/29/, 19 29, to 1/24/, 19 30, that I last saw h[illegible] alive on Jan 24, 19 30, and that death occurred, on the date stated above, at 10.05 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) [illegible] yrs.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Clinical + Necropsie

(Signed) [illegible], M. D.

1/24/, 30 (Address) 108 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means, and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ch. — DATE OF BURIAL Jan 25 1930

20 UNDERTAKER J. L. Brown & Son — ADDRESS 108 W. Monroe

Spec.—2-29-28—L. F. S.—500 Blks.

53356

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53356

CERTIFICATE OF DEATH

161-001

53356

1—PLACE OF DEATH Woman's Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 27-46 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Premature Boy Fuller

(a) RESIDENCE NO. 610 Blackburne Lane ST., — WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 1 ds. How long in U. S., If foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-22-30

7 AGE — Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Walter Morris Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Mary Bonner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nebraska

14 Informant

(Address) Mother

15 1-25 1930 — 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-22-30

17 I HEREBY CERTIFY, That I attended deceased from 1-22-30, 19..., to ..., 19...

that I last saw him alive on Jan. 22, 1930

and that death occurred, on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity - 7 months

(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G. Murray Jr., M. D.

1-23, 1930 (Address) 14 Tatchase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carnegie Laboratories

DATE OF BURIAL ... 19...

20 UNDERTAKER: Embalmer

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

OLEKSIEWICZ

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53357 101-80 E 53357

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 2-4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julian Olikjewicz

(a) RESIDENCE NO. 616 S. Ann ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Julian~~ LYCJA, OLEKSIEWICZ

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant LYCJA Olikjewicz

(Address) 616 S. Ann St

15 Filed 2 5 1930 C. HAMPSON JONES, M. D. Registrar

By RBH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-23 .1930. to 1-24 .1930.

that I last saw him alive on 1-24 .1930.

and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery DATE OF BURIAL Jan 27 1930

20 UNDERTAKER George A. Weber ADDRESS 705 S. Ann St

THIS IS very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 46 ✓ E 53358

REGISTERED NO. 15-67

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3105 Walbrook Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna Laura Duckett

(a) RESIDENCE NO. Davidsonville, Md. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank S. Duckett

6 DATE OF BIRTH (month, day, and year) July 17, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER David W. Downey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co., Md.

12 MAIDEN NAME OF MOTHER Laura V. Urie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co., Md.

14 Informant Mr. David W. Downey

(Address) 3105 Walbrook Ave.

15 Filed 2 5 1930, 19 C. H. WILSON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to Jan. 24th, 1930.

that I last saw her alive on Jan 24th, 1930

and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus with metastases —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Clinical & Operation several years ago

(Signed) M. P. Boyerly, M. D.

, 19 (Address) 3014 Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cemetery	Jan 27 1930
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53359 44 E 53359

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 N. Chester ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles A. Corame

(a) RESIDENCE NO. 1749 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie L. Corame

6 DATE OF BIRTH (month, day, and year): Oct 14/1871

7 AGE: Years 58 | Months 3 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Mutual Chemical Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm Corame

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Henrietta Leff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Carrie L. Corame

(Address) 1749 N. Chester St.

15 Filed 1 25 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 23/30

17 I HEREBY CERTIFY, That I attended deceased from November 1/29 to Jan 23/30, 19..,

that I last saw him alive on Jan 23/30

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Fibrous Sarcoma rt lung (focus not determined)

Metatases to liver (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no- Xray at Hopkins

What test confirmed diagnosis?

(Signed) J. S. H. Cater, M. D.

1/24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: Jan 27 1930

UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53360

CERTIFICATE OF DEATH.

E.S. 3360

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2614 Brenton St. 43-59 WARD)

2-FULL NAME Jas. E. Hayes

(a) RESIDENCE NO. 2614 Brenton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ of Minnie Hayes

6 DATE OF BIRTH (month, day, and year) [illegible] 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Dennis Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Minnie Hayes
(Address) 2614 Brenton

15 Filed ..... 19 .....

C. HAWSON JONES, M. D. Registrar

25 1930

Rod

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 19, 1930, to January 24, 1930, that I last saw him alive on January 23, 1930, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

a Lobar Pneumonia

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) none

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelteau M. D.

, 19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Va	1-26 1930
20 UNDERTAKER	ADDRESS
Geo. T. A. Gibson	1735 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53361

CERTIFICATE OF DEATH.

45 E 53361

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Josephs Hospital ST. 16-27 (WARD)

2-FULL NAME Mary B. Ford.

(a) RESIDENCE NO. 146 E. 41st near Eastern Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. Life? ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) Feb. 4, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Ford

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country) Penna

12 MAIDEN NAME OF MOTHER Anna M. Robinson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant (Address) Mrs. Frank F. Foulke (Sister) Essex Md.

15 Filed 2 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-17 1930 to 1-25 1930,
that I last saw her alive on 1-25 1930,
and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of colon.
(Splenetic flexure)
?

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Coronary thrombosis

(duration) Few minutes yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 1-17-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) J. M. Hundley, M. D.

19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Jan 25 1930

20 UNDERTAKER: Henry Sauder & Sons Inc

ADDRESS: Eutaw St & Baltimore

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

2331 E 53362

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 131 ✓ E 53362

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer Dorer

(a) RESIDENCE NO. 205 - Hanes St. - ST. WARD Harrisburg - Pa -
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret —

6 DATE OF BIRTH (month, day, and year) July 7 - 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U - S -

PARENTS

10 NAME OF FATHER Martha's Elmer -

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 ~~MAIDEN~~ NAME OF MOTHER Margaret Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y -

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 16 - 1930, to Jan 24 1930, that I last saw him alive on Jan 24 1930 and that death occurred, on the date stated above, at 11 45 A. M.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy,
General arteriosclerosis. Chr. nephritis
& acute pulmonary oedema
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bilateral Pyelonephritis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harrisburg, Pa.

Did an operation precede death? No - Date of —

Was there an autopsy? Limited, Yes.

What test confirmed diagnosis? Pus in urine, blood chemistry.

(Signed) G. A. James, M. D.

19 (Address) Johns Hopkins Hosp Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown Pa

DATE OF BURIAL 1/26/ 1930

UNDERTAKER Wm Cook

ADDRESS 127 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 533663 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ E 533663

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital REGISTERED NO. 32

CITY OF BALTIMORE: (No. Lombard & Green ST. 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilbur P Hines Jr

(a) RESIDENCE NO. 903 East E, Sparrows Pt. Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 25 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER Wilbur P Hines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Petersburg W Va

12 MAIDEN NAME OF MOTHER Thelma V Allison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gas City Ind

14 Informant Mr Wilbur P Hines

(Address) 903 E st Sparrows Pt

15 Filed JAN 25 1930 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 24, 1930,

that I last saw him alive on Jan 24, 1930

and that death occurred, on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter B. Johnson, M. D.

Jan, 1930 (Address) Universities Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	Jan 28 1930
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

Spec.—1-12-29—M&T—500 Bks.

E 53364 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 3704 Overlea ave ST. 27th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul E. W. Becker

(a) RESIDENCE No. 3704 Overlea ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice R. Becker

6 DATE OF BIRTH (month, day, and year) Sept 24 77

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Bakery

(c) Name of employer General Baking Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alice R. Becker

(Address) 3704 Overlea Ave.

15 Filed 1-25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 23 1930

17 I HEREBY CERTIFY, That I attended deceased from December 28, 1929, to Jany 23, 1930, that I last saw h~~im~~alive on Jany 23, 1930, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia (General)

(duration) — yrs. — mos 23 ds.

CONTRIBUTORY (Secondary) Cervical Adenitis

(duration) — yrs. — mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Green, M. D.

1/25 1930 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cimetery DATE OF BURIAL Jan 27 30

20 UNDERTAKER Frederick Lasselmo Sons ADDRESS Fallerton

Cor.—10-10-29—A Co.—100 Bks.

B 53365

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001

B 53365

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 122 S. Regester St. St. 2-4 Ward)

2-FULL NAME John Michalkiewicz

(a) RESIDENCE NO. 122 S. Regester St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eva Michalkiewicz

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O'Ho
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Rusia

PARENTS

10 NAME OF FATHER Peter Michalkiewicz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Rusia

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Rusia

14 Informant Eva Michalkiewicz
(Address) 122 S. Regester St.

15 Filed ..... 19.. C. [illegible] JONES M. D.
Registrar

25 1930 ... 4PM

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acc.
Ill Gas Poisoning
(duration) — yrs. — mos. 4 hrs
CONTRIBUTORY Asphyxia
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —
(Signed) G. E. Elades, M. D.
19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Land Cem	Jan 27 19 30
20 UNDERTAKER F. W. Rzazewski	ADDRESS 1954 Eastern

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E. 53366.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53366 90 E 53366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2885 Kinsey ave S 70-69 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Lowe

(a) RESIDENCE NO. 2885 Kinsey Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Joseph A. Lowe

6 DATE OF BIRTH (month, day and year): Nov. 25, 1865

7 AGE: Years 64 | Months 2 | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): Maryland.

10 NAME OF FATHER: Frederick Lammann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Rush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Jos. A. Lowe 2885 Kinsey ave

15 Filed ..... Registered ..... C. HAMPSON JONES, M. D. Registrar

N 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/26 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/26, 1930, to 1/26, 1930, that I last saw h alive on 1/26, 1930, and that death occurred, on the date stated above, at 4 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): acute Cardiac dilatation

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: Jan 28 1930

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

Spec.—12-9-25—A Co.—200 Bks.

E 53367

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 53367

CERTIFICATE OF DEATH.

129 [redacted]

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 800 N. North Ave St. 13-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph J. Fay

(a) RESIDENCE NO. 800 N. North Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Belle H. Fay.

6 DATE OF BIRTH (month, day, and year) Dec-17-1850

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	79	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer Clothing

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Fay

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Yetta Fay

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Sidney Mayer

(Address) 614 W. North ave

15 Filed 1-26 1930 19 H. H. Ruff Registrar

by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/30 19

17 I HEREBY CERTIFY, That I attended deceased from 1/10 1930, to 1/25 1930

that I last saw h[illegible] alive on 1/25 1930

and that death occurred, on the date stated above, at 12:10 P.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) C. Weston Smith, M. D.

1/26, 1930 (Address) 617 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clm Hebrew Friendship — Date of Burial 1/27/1930

20 UNDERTAKER J. Ahrens & Co — ADDRESS [redacted]

Spec.—8-16-29—L. F. S.—100 Bks.

653368

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53368

CERTIFICATE OF DEATH

24001 E 53368

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1213 Myrtle Ave ST. 7-24 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm Leonard

(a) RESIDENCE NO. 1213 Myrtle Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 1 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos. B. Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Elizabeth Wilkes

(Address) 1213 Myrtle Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 14 1929 to Jan 24 1930, that I last saw him alive on Jan 24 1930, and that death occurred, on the date stated above, at 9-25 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 27 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw J. Kelley, M. D.

Jan 25 1930 (Address) 1200 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	1/26 1930

20 UNDERTAKER Samuel P Kemsley ADDRESS 578 N Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

E 53369

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53369

CERTIFICATE OF DEATH

REGISTERED NO. E 53369

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 Andrew St ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret E. Murphy

(a) RESIDENCE NO. 1436 Andrew St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widdow

a If married, widowed, or divorced HUSBAND of (or) WIFE of James Murphy

6 DATE OF BIRTH (month, day, and year) Feb 10 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	52	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Franklin Kasper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Fanny Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs James Murphy

(Address) 1436 Andrew St

15 Filed JAN 26 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan, 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929 to Jan 24, 1930

that I last saw h alive on Jan 24, 1930 7 30 a m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

Duration Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

1/25, 1930 (Address) 6644 Stanton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Jan 27 1930

20 UNDERTAKER Chas. L. Stevens ADDRESS 1500 E Fort Ave

Spec.—1-12-23—M&T—500 Blks.

E 53370

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53370

CERTIFICATE OF DEATH.

100-001

E 53370

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp ST. 10-14 WARD)

2-FULL NAME Bettie Goldstein

(a) RESIDENCE No. 723 Freemont ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Dan Goldstein

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mr. Goldstein

(Address) 723 Freemont Ave

15 Filed JAN 26 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Jan 24, 1930, that I last saw her alive on Jan 24, 1930 and that death occurred, on the date stated above, at 10:05 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Typical Blood

(Signed) J. A. Olsen, M. D.

1/26, 1930 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest

DATE OF BURIAL 1/26 1930

20 UNDERTAKER Jack Levin

ADDRESS 1409 E Balto St

Spec.—1-10-21—M&T—1500 Blks.

Lolej 46 ✓ E53371

1929 90 4

E 53371 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53371

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caution & Lucas ST. 5 1 WARD)

2-FULL NAME Mrs Munzie Lolej

(a) RESIDENCE NO. 742 S. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of Otto L Lolej

6 DATE OF BIRTH (month, day, and year) Dec 21 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Stanglin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Teresa Fox 2217 Eutaw Pl

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1930

I HEREBY CERTIFY, That I attended deceased from Jan. 22 1930 to Jan 25 1930, that I last saw her alive on Jan 25 1930, and that death occurred, on the date stated above, at 12.18 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis X

Chronic Cholecystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mon. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Jan. 23, 1930

Was there an autopsy? No Dr. [illegible]

What test confirmed diagnosis? clinical

(Signed) Vincent Messina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 1/29/1930

UNDERTAKER H B Kuykendall

ADDRESS 850 W Balto St

TION IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Bks.

Weber

E 53372

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 53372

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 N Baltimore St.) (WARD) 20-6-9

2—FULL NAME Margaret L. Weber

(a) RESIDENCE NO. 2809 N. Baltimore St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 22nd 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	2	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Geo H. Weber

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Schaub

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Geo H. Weber

(Address) 2809 N. Baltimore St

15 JAN 26 1930 HOUR OF DEATH P.M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to Jan 25, 1930,

that I last saw h. ex. alive on Jan 20 1930

and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

3 Years

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kelly, M. D.

1/26, 1930 (Address) 1027 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Jan 28th 1930

20 UNDERTAKER J. B. Wiglesworth

ADDRESS 1100 N. Baltimore St

Spec.—2-29-28—L. P. S.—500 Blks.

E 53373.

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

CERTIFICATE OF DEATH

E 53373

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 N. Hare ST., 6 (WARD)

2—FULL NAME Johanna T. Nentze

(a) RESIDENCE NO. 140 N. Hare ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Harry T. Nentze

6 DATE OF BIRTH (month, day, and year) Feb. 21st 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	43	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Gaff

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Maria Sullens

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mr. William P. McEwen
(Address) 1206 N. 67 st.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1/29, 19..., to Jan. 24, 1930

that I last saw h 21 alive on Jan. 24 1930

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.
R. Tuberculosis.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. H. Monnes M. D.

19 (Address) 14. E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Jan. 27th 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St

HAMPSON JOHNS

Spec.—2-29-28—L. F. S.—500 Blks.

✓ E 53374

HEALTH DEPARTMENT—CITY OF BALTIMORE

53374

CERTIFICATE OF DEATH

129 E 53374

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 S. Patterson Pk Ave WARD 12)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia G. Sommers.

(a) RESIDENCE NO. 611 S. Patterson Pk Ave WARD 1
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Sommers

6 DATE OF BIRTH (month, day, and year) Sept. 12th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
64 65		4	13 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Wiley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Louise Christian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Benjamin Sommers

(Address) 611 S Patterson Pk Ave

15 Filed ..., 19 ... C. HAWSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25th 1930

17 I HEREBY CERTIFY, That I attended deceased from ..., 1929, to Jan. 25, 1930, that I last saw h[illegible] alive on Jan. 25, 1930 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. H. D. Tippy M. D.

(Address) 43 S. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Jan 28 1930
20 UNDERTAKER	ADDRESS
Kirby & Zeiler Inc.	403 S. Wolfe St

Spec.—8-16-29—L. F. S.—100 M. E 53375 Dr Gahring 1900 Eastern Av Wolf 3980 9 to 10 Saturday

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53375

CERTIFICATE OF DEATH

92 E 53375

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1214 N. Aisquith St. 10-14 WARD)

2—FULL NAME August Meyers

(a) RESIDENCE NO. 1214 N. Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Meyers

6 DATE OF BIRTH (month, day, and year) Sept 4th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Sykesville Md

PARENTS

10 NAME OF FATHER Ernst Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kate Meyers

(Address) 1214 N. Aisquith st

15 Filed ..... 19.. C. HAMILTON JONES, Registrar

M 26 1930 By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 11 1929, to Jan 23 1930, that I last saw h alive on Jan 12 1930 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J Grimes, M. D.

Jan 25, 1930 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	1/27/1930
20 UNDERTAKER Wm Cook 1217 St	ADDRESS Paul St

E53376. Jos. Palmisano 14 & Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53376 Lot 2, Pessagno 90, 2314 E. Balto St

CERTIFICATE OF DEATH

E 53376

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5002 Harford Ave ST. 27-45 WARD)

2—FULL NAME Concetta Tringale

(a) RESIDENCE NO. 5002 Harford Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatore Tringale

6 DATE OF BIRTH (month, day, and year) Dec 23 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Pietro Ferruggia

(Address) 5062 Harford Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Jan. 24, 1930, that I last saw h[e] alive on Jan. 24, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis (Chronic)

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pennuto, M. D.

1-26, 1930 (Address) 519 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 26 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 N. Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53377 Dr. Fenby 1223 N. Caroline 100-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53377

REGISTERED NO. E 53377

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2805 Pinewood Ave. 27-43 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry S Glenn

(a) RESIDENCE NO. 2805 Pinewood Ave ST. Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31st 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector ✓

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 61 ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Glenn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Lydia Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Henry McNeal

(Address) 2805 Pinewood Ave

15 Filed 2 8 1930 C. H. JACKSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 13 — 1930, to Jan. 24 1930, that I last saw h.i.m. alive on — 1930 and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis, Uncertain (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

1/25/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 1/27/1930

20 UNDERTAKER Wm Cook

ADDRESS St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

H. Hawkins
I E Randall
S 0110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53378

REGISTERED NO. E 53378

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 East Lafayette ST., 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate F. Lucas

(a) RESIDENCE NO. 1407 East Lafayette ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William O. Lucas

6 DATE OF BIRTH (month, day, and year): May 18-1860

7 AGE — Years: 69 — Months: 8 — Days: 17 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Whitley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Julia Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Maggie Eckstein
(Address) 1407 Reisterstown

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan-25-1930

17 I HEREBY CERTIFY, That I attended deceased from March 29 19 24 to Jan 25 1930, that I last saw ... alive on Jan 24 1930 and that death occurred, on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows: Senile Myocarditis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Diabetes (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) ... M. D.

1/26 1930 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Jan-28 1930

20 UNDERTAKER: William Cook — ADDRESS: 1215 N Gay

Cor.—12-9-25—A Co.—200 Bks.

Coroner Kelly 25-3379

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 E 53379

E 53379

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 46 Market Place St. 3-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter H Evans

(a) RESIDENCE NO. 46 Market Place St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence A. Evans

6 DATE OF BIRTH (month, day, and year) Oct 31, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bermuda

PARENTS

10 NAME OF FATHER James E. Evans

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bermuda

12 MAIDEN NAME OF MOTHER Sarah Saunders

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bermuda

14 Informant Florence A. Evans

(Address) 1531 Patterson Park Ave

15 Filed JAN 26 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Duration (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

Jan 26, 1930 (Coroner)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Date of Burial Jan 27 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Blks.

✓ ES-3380

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53380

CERTIFICATE OF DEATH

24-001

12-58

E 53380

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 East 25th.St. ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Donohue

(a) RESIDENCE NO. 325 East 25th. St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Rochfort Donohue

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John T. Donohue

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cecelia Finley

13 BIRTHPLACE OF MOTHER (city or town) Mt. Savage (State or country) Maryland

14 Informant Mrs. Katie R. Donohue

(Address) 325 E. 25th Street

15 Filed JAN 29 1930, 19 ... Registrar ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 12th, 1930, to January 23rd, 1930, that I last saw h... alive on January 23rd, 1930 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) 6 Wks. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cowdalumm M. D.

, 19 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 1/27 19 30

20 UNDERTAKER Henry A. Meares & Son

ADDRESS 705 N. Calvert

Spec.—8-16-29—L. F. S.—100 Bks.

53381 E 53381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 53381

E 53381

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 S Eastern Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Gaetzinger

(a) RESIDENCE NO. 20 S Eastern Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August Gaetzinger

6 DATE OF BIRTH (month, day, and year): Aug 17 1853

7 AGE: Years 77 | Months 5 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: ? Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Tessa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Clara Mitchell (Address) 20 S Eastern Ave

15 Filed JAN 26 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-25-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1930 to Jan 25 1930

That I last saw her alive on Jan 25 1930 at 11:30 a.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility Cardiac Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred Ruffner M. D.

1-27 1930 (Address) 700 N Butler

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Jan 27 1930

20 UNDERTAKER: M. F. & E. Dippel Inc — ADDRESS: 32 Lloyd

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53382

CERTIFICATE OF DEATH.

129

E 53382

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 7-56 WARD)

2-FULL NAME Joseph L. Kaufman

(a) RESIDENCE No. 1213 Belvedere Ave ST.. WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: 60 (Years / Months / Days / If LESS than 1 day, hrs. or ... min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Samuel B Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Carb Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant, (Address): Mrs C. L. Banks 1213 Belvedere Ave

15 Filed [illegible], 19[illegible] [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-24 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/24, 1930, to 1-24, 1930, that I last saw h~~im~~ alive on 1-24, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis Chronic myocarditis with cardiac decompensation

(duration) yrs. 1 mos 14 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cumberland Pa — DATE OF BURIAL: 1/26/30

20 UNDERTAKER: S J Fahey Sons — ADDRESS: 1318 Light

TION is very important. See instructions on back of certificates.

N 2 01930

Spec.—8-16-29—L. F. S.—100 Blks.

E 53383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53383

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 26-37 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Casey

(a) RESIDENCE NO. None ST., WARD Non Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horseman

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N.Y.

PARENTS

10 NAME OF FATHER: Tobin Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Records Of

(Address) Balto. City Hospitals

15 Filed JAN 26 1930 STAMP JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-24-30

17 I HEREBY CERTIFY, That I attended deceased from 8-30-29, 19..., to 1-24-30, 19...,

that I last saw him alive on 1-24-30, 19...,

and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Jacute

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Tuberculosis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McLean, M. D.

1-24, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross ADC

DATE OF BURIAL: 1/27 1930

20 UNDERTAKER: J. F. Carey & Sons

ADDRESS: 1318 Eutaw St

Spec. 6-9-29—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53384

CERTIFICATE OF DEATH.

90

E 53384

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 919 Washington Blvd (ST.) 21-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Walters

(a) RESIDENCE. NO. 919 Washington Blvd. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mary E. Walters

6 DATE OF BIRTH (month, day, and year) Dec 6. 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Sarah Laishart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs. Alverta O'Brien 919 Washington Blvd

15 Filed JAN 25 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to Jan 24, 1930, that I last saw h alive on Jan 24, 1930, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) L. Earl Crumbacker, M. D.

(Address) 567 Lenox

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem Grant Sec	Jan 27 1930

20 UNDERTAKER Geo. L. Schwab

ADDRESS 701 Fulton Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53385

CERTIFICATE OF DEATH

111-001 V

E 53385 REGISTERED NO.

1-PLACE OF DEATH Mid General Hosp

City of BALTIMORE: (No. Howard & Madison St. 27-E Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Boyle

(a) RESIDENCE NO. 3600 Spalding Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie A. Boyle

6 DATE OF BIRTH (month, day, and year): Oct 16, 1875

7 AGE: 54 / 53 Years: Months 3. Days 8. IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer): Obs

(c) Name of employer

9 BIRTHPLACE (city or town): Chester Pa.

(State or country)

PARENTS

10 NAME OF FATHER: James Boyle

11 BIRTHPLACE OF FATHER (City or town): Limerick Pa

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Lewis

13 BIRTHPLACE OF MOTHER (city or town): Lewistown Pa

(State or country)

14 Informant: Mrs Rose Boyle

(Address)

15 Filed ....., 19.... Registrar

JAN 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 27, 19 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1930, to Jan 27, 1930, that I last saw him alive on Jan 24, 1930, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows: Perforated Gastric Ulcer

(duration) ....yrs. ....mos. 2 da.

CONTRIBUTORY (Secondary): Perforated Gastric Ulcer

(duration) ....yrs. ....mos. 7 da.

18 Where was disease contracted if not at place of death?: -

Did an operation precede death? Yes Date of Jan 27

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. Ruhlemann M. D.

1/24 1930 (Address) Mid General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chester Pa

Date of Burial: Jan 27 1930

20 UNDERTAKER: Thenowath Son

ADDRESS: 3600 Chester Ave

very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53386 49 E 53386

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 828 Union Ave. St. 43-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella N. Harrison.

(a) RESIDENCE NO. 828 Union Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Harrison.

6 DATE OF BIRTH (month, day, and year) Oct 3, 1865.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER John R. James

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey.

12 MAIDEN NAME OF MOTHER Susannah McClure

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant William Harrison.

(Address) 828 Union Ave.

15 Filed JAN 26 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Jan 24, 1930, that I last saw her alive on Jan 24, 1930 and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

Metastasis Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ascites

(duration) yrs 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. N. Wilson M. D.

19 (Address) 848 W. 36th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden.

DATE OF BURIAL Jan 27, 1930

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Chestnut Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 53387

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53387

CERTIFICATE OF DEATH

REGISTERED NO. 13-52 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3520 Elm Ave. ST. WARD)

2—FULL NAME James W. Kelley:

(a) RESIDENCE NO. 3520 Elm Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Kelley:

6 DATE OF BIRTH (month, day, and year) May 2, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Florence Kelley.

(Address) 3520 Elm Ave.

15 Filed ... C. H. ... Registrar.

JAN 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th, 19 30, to Jan 24th, 19 30, that I last saw him alive on Jan 24th, 19 30, and that death occurred, on the date stated above, at 11:25 a.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ... yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Chronic Nephritis, Arteriosclerosis

(duration) ... yrs. mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical & Microscopic

(Signed) H. A. Fillmore, M. D.

1/25, 1930. (Address) 2618 Vale Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL Jan 27, 19 30

20 UNDERTAKER Thomson-Gibson

ADDRESS 3615 Liberty Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53388

101-001

E 53388

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO. 21-29

CITY OF BALTIMORE: (No. 1514 Division ST. 21 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Holland

(a) RESIDENCE NO. 710 Hawe ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 25 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Chemical Works

(c) Name of employer

9 BIRTHPLACE (city or town) St Marys Co. Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Holland

11 BIRTHPLACE OF FATHER (city or town) St Marys Co.
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Loney

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co
(State or country) Md

14 Informant Kathe Holland (sister)

(Address) 1527 Myrtle Ave

15 Filed JAN 27 1930 H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-30

17

I HEREBY CERTIFY, That I attended deceased from Jan 23 [illegible] 30, to Jan 24, 1930,

that I last saw him alive on Jan 24, 1930

and that death occurred, on the date stated above, at 8 37 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

1/24, 1930 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Cem

DATE OF BURIAL 1/27 1930

UNDERTAKER Samuel Kinsley

ADDRESS [illegible]

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 E 53389

REGISTERED NO.

E 53389

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 S Port St. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Siedlik

(a) RESIDENCE NO. 825 S Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Ignatuis Siedlik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine Knuatek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Catherine Siedlik
(Address) 825 S Port St.

15 Filed JAN 27 1930 19 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 19 30

17 I HEREBY CERTIFY, That I attended deceased from 1/18 19 30 to 1-25 19 30

that I last saw her alive on 19

and that death occurred, on the date stated above, at 340P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Lagrippe

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Gerdes M. D.

1/26 1930 (Address) 1918 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem DATE OF BURIAL Jan 27 1930

20 UNDERTAKER John M Weber ADDRESS 1 Chester

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓

E 53390

1—PLACE OF DEATH

REGISTERED NO. 16-67

CITY OF BALTIMORE: (No. 1600 N. Hilton St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah Cary Bruton

(a) RESIDENCE NO. 1600 N. Hilton St. ST., WARD

(Usual place of abode) life (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Glenn Bruton

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Steuart Purcell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia P. Eichelberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Steuart Purcell

(Address) 1600 N. Hilton St.

15 Filed ..... 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25th 1930

17

I HEREBY CERTIFY, That I attended deceased from November 18 1929 to January 25 1930

that I last saw her alive on January 25th 1930

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) One yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In North Carolina

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. Funnell Largo, M. D.

19 (Address) 2937 W. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Jan. 27 1930

20 UNDERTAKER John O. Mitchell & Sons, 1900 Eutaw Pl.

ADDRESS

John O. Mitchell

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53391

CERTIFICATE OF DEATH.

101-001

E 53391

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Schroeder ST. 18-26 (WARD)

2—FULL NAME John Joseph Hardman

(a) RESIDENCE NO. 111 N. Schroeder ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	75	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer ptd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Calvert Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Hardman

11 BIRTHPLACE OF FATHER (city or town) Calvert Co, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Brown

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.
(State or country) Md.

14 Informant James E. Hardman
(Address) 539 W. Saratoga St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1930, to Jan 24, 1930, that I last saw h.m alive on Jan 23, 1930, and that death occurred, on the date stated above, at 2.00 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Mace Williams, M. D.

1-25. 1930 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mutual Calvert Co. Md

DATE OF BURIAL Jan 28, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 327 N Schroeder St

FEB 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 53392

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53392

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1918 Druid Hill Ave) (Ward) 44-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie Butler

(a) RESIDENCE NO. 1918 Druid Hill Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 4 mos. 4 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Butler

6 DATE OF BIRTH (month, day, and year) Oct - 28. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
53 54	2	25 26		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid - Ofc

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Aged Woman's Home. Charles Co

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Nace Smallwood

11 BIRTHPLACE OF FATHER (city or town) Charles Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Smallwood

13 BIRTHPLACE OF MOTHER (city or town) Charles Co (State or country) Maryland

14 Informant Grace Edwards

(Address) 1607 W Fremont

15 Filed JAN 27 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 23 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan 23, 1930

that I last saw h er alive on Jan - 22, 1930

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Acute Lobar)

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Uraemia - Chr Nephritis?

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urine Albumin + Casts +++

(Signed) David Druecker, M. D.

1/25 1930 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL Jan 27 1930

20 UNDERTAKER Mrs. Kate R Williams

ADDRESS 322 N Schroeder St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53393

188-008 53393

CERTIFICATE OF DEATH

27-43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St. Joseph Hospital St., (Ward)

2-FULL NAME Harry T. Kirwan, Jr.,

(a) RESIDENCE NO. 2304 Evergreen Ave., (Hamilton) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6/1924

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	5	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Harry T. Kirwan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Fannie Clingman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Harry T. Kirwan
(Address) 2304 Evergreen Ave

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24/30 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull-Intracranial Hem. Accidental- Collided with parked automobile 5512 Traymore Ave while sledding Jan 23/30 (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Kirwan, M. D.

1/25/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Jan. 27 1930
20 UNDERTAKER	ADDRESS
C. Miller & Son	2324 Jefferson

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53394

E 53394

CERTIFICATE OF DEATH

REGISTERED NO. 1-60 15-60

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 N. Pulaski ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lee William Herndon

(a) RESIDENCE NO. 2114 N. Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 15/1929

7 AGE — Years | Months: 3 | Days: 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm L. Herndon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Oklahoma

12 MAIDEN NAME OF MOTHER: Agnes Applebey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Wm L. Herndon

(Address) 2114 N. Pulaski St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 26-1930

17 I HEREBY CERTIFY, That I attended deceased from 1-26- 1930 to 1-26- 1930

that I last saw him alive on 1-26 1930

and that death occurred, on the date stated above, at 5 30 p m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lu Complic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Wheeler M. D.

1-27 1930 (Address) 2129 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Jan 27 1930

20 UNDERTAKER: Harry W. Eblen

ADDRESS: 924 W. North Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 53395

CERTIFICATE OF DEATH

E 53395

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST 5-8 WARD)

2—FULL NAME George F. Strahler

(a) RESIDENCE NO. 1007 E Fort St. Balto ST., WARD [redacted]
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory worker 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. H. Strahler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie H. Kaiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs John J. Strahler

(Address) Woodlawn Md

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1930, to Jan 25, 1930, that I last saw h[illegible] alive on Jan 25, 1930 and that death occurred, on the date stated above, at 11 [illegible] p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

indefinite Amatium (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) unknown (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jas E Strahler M.D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL JAN 28 1930

20 UNDERTAKER Geo W Settles

ADDRESS 2700 EDMONDSON AVE.

Spmk—1-13-23—M&T—500 Blks.

E 53306

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53306

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Clara Traisch

(a) RESIDENCE NO. Anne Arundel Co. Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Traisch

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Thrush

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Colgate

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Pikesburg

14 Informant Fred Traisch

(Address) Southern Ave & Locust Pt

15 Filed N 27 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 30, 1929, to Jan 24, 1930,

that I last saw her alive on Jan 24, 1930

and that death occurred, on the date stated above, at 4 45a m

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Cerebral thrombosis

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. D. Glenn M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DATE OF BURIAL Jan 27 1930

20 UNDERTAKER John J. Fahey Sons ADDRESS 1318 Light St

Spec.—2-29-28—L. F. S.—500 Blks.

E 53397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 53397

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2248 E Chase ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Magdalena V Blanck

(a) RESIDENCE NO. 2248 E Chase ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

6a If married, widowed or divorced HUSBAND of (or) WIFE of Frank V Blanck

6 DATE OF BIRTH (month, day, and year) Feb 26 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Martin Remminger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalena Wind

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lillian Skaras

(Address) 762 Poplar Grove St.

15 Filed JAN 27 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 24, 1930, that I last saw h er alive on Jan 24, 1930 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Degeneration

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Diffuse Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Grant Jayd M. D.

Jan 25, 1930 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 1-27 1930

ADDRESS Edmondson Ave

20 UNDERTAKER Wm Chas A Rohde 2327

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53398

E 53398

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St. Joseph Hospital St., 27-54 (Ward)

2-FULL NAME John Thompson

(a) RESIDENCE NO. 1440 Belvidere St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beulah Thompson

6 DATE OF BIRTH (month, day, and year) Mar 25/1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39	10	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Co., Va.

PARENTS

10 NAME OF FATHER Abraham Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Beulah Thompson

(Address) 1440 Belvidere

C. Thompson Jones, M. D.

Registrar

1930 19

COMMISSIONER OF HEALTH

Per Rec. Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 24/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage-Apoplexy

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? on street

Did an operation precede death? no Date of

Was there an autopsy? yes-Dr. McCleary

What test confirmed diagnosis?

(Signed) [signature], M. D.

1/27/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL 1/27 1930

20 UNDERTAKER Samuel J. Handley

ADDRESS 578 W. Baltimore St.

important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

E 53399

HEALTH DEPARTMENT—CITY OF BALTIMORE

24-001

E 53399

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General Hospital (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Elizabeth Sadler

(a) RESIDENCE NO. 628 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed.

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 23 61

7 AGE: 68 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Samuel Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Gadow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: mrs a Priddy

(Address) 1513 Fern Park Ave

15 Filed JAN 27 1930 C. HERBERT BOWIE, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-26-30

17 I HEREBY CERTIFY, That I attended deceased from 1-23, 1930, to 1-26, 1930

that I last saw her alive on 1-26, 1930

and that death occurred, on the date stated above, at 5.15 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Lankaitis, M. D.

19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Jan 27 1930
20 UNDERTAKER	ADDRESS
W M Routen	223 S N Smith

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53400

CERTIFICATE OF DEATH

74 001

E 53400

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Wyman Park apts ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Alie Toodle Gratty

(a) RESIDENCE NO. Wyman Park apts ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Gratty

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Joseph Mo

(State or country)

PARENTS

10 NAME OF FATHER Joseph W. Toodle

11 BIRTHPLACE OF FATHER (city or town) Ohio

(State or country)

12 MAIDEN NAME OF MOTHER Sarah McCord

13 BIRTHPLACE OF MOTHER (city or town) Virginia

(State or country)

14 Informant Mary King Toodle

(Address) New York City

15 Filed 27 1930 19 COMMISSIONER OF HEALTH

Registered by Reg.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 28, 1929, to Jan. 25, 1930, that I last saw h[illegible] alive on Jan. 24, 1930, and that death occurred, on the date stated above, at 6:45 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin P. Jarrett, M. D.

, 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London England

DATE OF BURIAL 1-29 1930

20 UNDERTAKER Henry W. Jenkins' Sons Co

ADDRESS Richard McCulloh.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 53401

REGISTERED NO. ____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 Washington Ave) (WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Mansdorfer

(a) RESIDENCE NO. 926 Wash Blvd WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Lillian Eastman
(Address) 92 Washington Blvd, M D

15 Filed JAN 27 1930 19 C. Hampson Jones, COMMISSIONER OF HEALTH
Registrar

Reg. Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-25-30

17 I HEREBY CERTIFY, That I attended deceased from 1-1-30, to 1-25-30, 19..., that I last saw h[illegible] alive on 1-25-30, 19... and that death occurred, on the date stated above, at 5.55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sanford Dann, M. D.

1/27/1930 (Address) 1209 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan 29 1930
20 UNDERTAKER Charles H Keehner	ADDRESS 535 Hollins

Spec.—8-16-29—L. F. S.—100 Bks.

E 53402 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53402

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 430 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard B. Wright

(a) RESIDENCE NO. Denton, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Howard B. Wright

6 DATE OF BIRTH (month, day, and year) August 1875

Years	Months	Days	If LESS than 1 day, hrs. or min.
54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Husb. Denton, Md.

(Address)

Filed 2 7 1930 C. Hampson Jones, M. D. COMMISSIONER OF HEALTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26/30

17 I HEREBY CERTIFY, That I attended deceased from 1/17, 1930, to 1/26, 1930, that I last saw him alive on 1/26, 1930, and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
& metastasis to mesenteric gland.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anaemia unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? yes Date of 1/8/30

Was there an autopsy? yes, partial,

What test confirmed diagnosis? Clinical & operation

(Signed) Henry D. Merrick, M. D.

1/26 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Denton Md DATE OF BURIAL Jan 27 1930

20 UNDERTAKER Wm J Tuckner & Sons ADDRESS N. Y. Pa

Reg. Clerk

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53403

CERTIFICATE OF DEATH

× 90

E 53403

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1746 E North Ave. ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Roberts Evans

(a) RESIDENCE NO. Edmondson Av. North Bond 27 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 49 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of David E. Evans

6 DATE OF BIRTH (month, day, and year) Sept 19 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Cardiff
(State or country) Wales

PARENTS

10 NAME OF FATHER Josiah Roberts

11 BIRTHPLACE OF FATHER (city or town) Cardiff
(State or country) England

12 MAIDEN NAME OF MOTHER Mary A Holmes

13 BIRTHPLACE OF MOTHER (city or town) Cardiff
(State or country) England

14 Informant Mr Edwards (son-in-law)
(Address) Edmondson Ave North Bond 27

15 Filed JAN 27 1930 Dawson Jones, M. D.
COMMISSIONER OF HEALTH
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1929, to Jan 26, 1930, that I last saw her alive on Jan 14, 1930 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Marshall B. Lerst, M. D.

Jan 27 1930 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	Jan 29 1930
20 UNDERTAKER Stewart & Mowen Co	ADDRESS Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53404

CERTIFICATE OF DEATH

90

REGISTERED NO. E 53404

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 210 Witherspoon Rd (ST.) 27-48 (WARD)

2—FULL NAME Louise Thomson Ford

(a) RESIDENCE NO. 210 Witherspoon Rd. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if foreign birth 54 yrs. 11 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feby-7-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Penna.

PARENTS

10 NAME OF FATHER David R. Ford

11 BIRTHPLACE OF FATHER (city or town) Phila.
(State or country) Penna

12 MAIDEN NAME OF MOTHER Emma E. Thomson

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Mr. Horace R. Ford (Son) M. D.
(Address) 210 Witherspoon Road.

Filed JAN 27 1930, 19 ..... Registered ..... by .....

COMMISSIONER OF HEALTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Jan 27, 1930, that I last saw h alive on Jan 27, 1930 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Lobular Endocarditis

unknown
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) none
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopay? no

What test confirmed diagnosis? ✓

(Signed) Jefferson Busco M. D.

1/27 1930 (Address) 5 Clark Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Jan 30 1930.

20 UNDERTAKER Stewart & Monnett — ADDRESS Balto.

Cor.—10-10-29—A Co.—100 Bks.

E 53405

HEALTH DEPARTMENT—CITY OF BALTIMORE

V-009

E 53405

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hosp St., 4-7 Ward)

2-FULL NAME Benj. Harrison Deal

(a) RESIDENCE NO. Ashland Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 1-1914

7 AGE Years 15 Months 4 Days 25 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ashland
(State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Benj F. Deal

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Bessie Lyons

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. B. F. Deal
(Address) C. Ashland Md

15 Filed JAN 27 1930 COMMISSIONER OF HEALTH

For Reg. Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
While coasting on a sled he ran into moving automobile &c.

(duration) 1 hr. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull - Central Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? York Rd nr Ashland

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) G J Braun, M. D.

1/27 1930 (Address) 2939 11th Edg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Josephs Govans, Md	Jan 30 1930
20 UNDERTAKER	ADDRESS
Wm C Burke & Son	Govans, Md

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53406

CERTIFICATE OF DEATH

101-001

E 53406

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2421 Paca St. 25-37 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Cole

(a) RESIDENCE NO. 2421 Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1929

7 AGE: Years — | Months 7 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Eugene Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ida Brookes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida Cole

(Address) 2420 Hampton Echos, Md

15 Filed JAN 27 1930, 19 COMMISSIONER OF HEALTH Registrar

For Dep. Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930, to Jan 27, 1930, that I last saw alive on Jan 25, 1930 and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) 4 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease cantracted if not at place of death? residence

Did an operation preceda death? no Data of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Burtlacken, M. D.

19 (Address) Gokeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	1-27-30
UNDERTAKER	ADDRESS 916
Daniel Carter	Park ave.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53407

E 53407

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 508 N Canselton St. (Hospital) 18-W (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Hawkins

(a) RESIDENCE NO. 508 N Canselton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (Odd)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Pauline Hawkins (Address) 508 N. Canselton St.

15 Filed JAN 27 1930 COMMISSIONER OF HEALTH Registrar

Reg. Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-25-30

17 I HEREBY CERTIFY, That I attended deceased from 1-23, 1930, to 1-25, 1930

that I last saw h— alive on 1-24, 1930

and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease.

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) 4 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Clinical

What test confirmed diagnosis?

(Signed) H. Hackerman, M. D.

1-27 1930 (Address) 600 Ashburton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	1-27 1930
20 UNDERTAKER	ADDRESS 916
David Carter	Penna ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53408

CERTIFICATE OF DEATH

E 53408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1411 W Preston St., Ward 15-21)

2-FULL NAME Effie Drago

(a) RESIDENCE NO. 1411 W Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Archie Drago

6 DATE OF BIRTH (month, day, and year): Jan 20 - 1905

7 AGE: Years 25 | Months — | Days 4 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9 BIRTHPLACE (city or town) Edna Co Md
(State or country)

PARENTS

10 NAME OF FATHER Arthur Smallwood

11 BIRTHPLACE OF FATHER (city or town) Md.,
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Campbell

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Archie Drago
(Address) 1411 W. Pres.

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death by ..... (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) ..... M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Md | DATE OF BURIAL: Jan 28 1930

20 UNDERTAKER: Jam. E. Chase & Son | ADDRESS: Woodlawn

Reg. Clerk

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53409

CERTIFICATE OF DEATH

117

E 53409

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital 5-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Kent

(a) RESIDENCE NO. 1558 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Kent

6 DATE OF BIRTH (month, day, and year) Mar 12 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Merchants & Miners

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edw Kent

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Boyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bertha Kent

(Address) 1558 Woodyear

15 Filed 1-27-30 C. Hampson Jones, M. D. Registrar

COMMISSIONER OF HEALTH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-23 1930, to 1-26 1930,

that I last saw him alive on 1-26 1930,

and that death occurred, on the date stated above, at 1.26 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

Duodenal Obstruction

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/23/30

Was there an autopsy? Yes Chemical-autopsy

What test confirmed diagnosis?

(Signed) B Hamm, M. D.

1-26, 1930 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF DISPOSITION OR REMOVAL Garrison Chapel

DATE OF BURIAL 1-28 1930

20 UNDERTAKER Thomas E Wright

ADDRESS 1634 Mary

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53410

101-001 ✓

E 53410

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 4104 Roland Ave St. 13-52 (Ward)

2-FULL NAME Harry P. Strasbaugh

(a) RESIDENCE NO. 4104 Roland Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Husband of Anna Bayless Strasbaugh

6 DATE OF BIRTH (month, day, and year) March 27-1867

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
62	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Roland Oil

(b) General nature of industry, business, or establishment in which employed (or employer) Printing Packer

(c) Name of employer Self.

9 BIRTHPLACE (city or town)

(State or country) Harford Furnace Md

PARENTS

10 NAME OF FATHER A. Henry Strasbaugh

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Isabella Pannell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Co

14 Informant Dorothy McGuigan

(Address) Baltimore, Md.

C. HARPSON JONES, Ass't.

15 Filed ..... 19 ..... Registrar

71930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 30

27 January

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 19 30, to Jan 27, 19 30

that I last saw h alive on Jan 27, 19 30

and that death occurred, on the date stated above, at 9.30 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Standish McAlister, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Churchville Cemetery Jan 29 1930

20 UNDERTAKER Bayard Co ADDRESS

Henry Sarrington Glenwood

Be sure that all items are answered, or that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 53411

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53411

CERTIFICATE OF DEATH.

REGISTERED NO. 118

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 247 S. Ann St. 2-4 WARD)

2-FULL NAME Selma Pawlak

(a) RESIDENCE NO. 247 S. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 1, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Pawlak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Marie Saltysiak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): James Pawlak 247 S. Ann St.

15 Filed 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-26-1930

17 I HEREBY CERTIFY, That I attended deceased from 8-6-, 1926, to 1-26-, 1930, that I last saw her alive on 1-25-, 1930, and that death occurred, on the date stated above, at 12 30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary) Tetany

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 12/7/29

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Fred B. Sybert, M. D.

, 19 (Address) 2801 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cemetery

DATE OF BURIAL: June 30 1930

20 UNDERTAKER: George A. Weber

ADDRESS: 706 S. Ann St.

TION is very important See instructions on back of certificates.

27 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 53412

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53412

CERTIFICATE OF DEATH

1—PLACE OF DEATH U.S. Marine Hospital, Balto., Md. REGISTERED NO. 44

CITY OF BALTIMORE: (No. 24-35 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sven Pearson

(a) RESIDENCE NO. 1401 Reynolds St., Balto., Md. ST. WARD Sweden
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	54	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Pennmar

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Par Gunderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Helena Haraldsson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Filed 2 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to January 26, 1930, that I last saw him alive on January 26, 1930 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis: Clinical, xray & laboratory

(Signed) Ralph E Porter, M. D.

1/27, 19 30 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's, Hampden	Jan. 28, 1930
20 UNDERTAKER E. Leroy Stiffler, Inc.	ADDRESS 125 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53413

CERTIFICATE OF DEATH.

53413

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1616 McCulloh — St. 14 (Ward) 70

2-FULL NAME Percival Ming

(a) RESIDENCE NO. 1616 McCulloh — ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Cecelia Ming

6 DATE OF BIRTH (month, day, and year) 1873 Not Known

7 AGE: 57 (Years / Months / Days)

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer): Apartment House

(c) Name of employer: Hurst Co

9 BIRTHPLACE (city or town) (State or country): Bermuda

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bermuda

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Cecilia Ming (Wife)
(Address) 1616 McCulloh

15 1 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 12/30 — 1930 to Jan 25 1930, that I last saw him alive on Jan 24th 1930, and that death occurred, on the date stated above, at 7:20 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis (Cerebral)

Abt (duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Hypertension (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Samuel A Bam, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: 1 28 1930

20 UNDERTAKER: Chas. J. Kemp — ADDRESS: 578 N. Eutaw

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53414

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53414

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 15-21 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Benton

(a) RESIDENCE NO. 1619 Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dalatha Benton

6 DATE OF BIRTH (month, day, and year) march 6 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. N+O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Will Benton

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina.

12 MAIDEN NAME OF MOTHER Eula Hagley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina.

14 Informant Dalatha Benton

(Address) 1619 Prestman St

JAN 27 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27-30

17 I HEREBY CERTIFY, That I attended deceased from 1-14, 1930, to 1-25, 1930, that I last saw h[illegible] alive on 1-23 1930 and that death occurred, on the date stated above, at 5:20 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) J Heyko M. D.

1/27, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cheraw, S. Carolina.	Jan 29 1930
20 UNDERTAKER Thomas E Kelson	ADDRESS 1303 Preston St

Spec.—1-12-23—M&T—500 Blks.

E 53415 HEALTH DEPARTMENT—CITY OF BALTIMORE 101 801 E 53415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 707 N. central ST. 10-14 (WARD)

2-FULL NAME Richard Coffee

(a) RESIDENCE NO. 707 N central ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 9, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	yrs 6	22 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... (State or country) Virginia

PARENTS

10 NAME OF FATHER William Coffee

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Virginia

14 Informant Lonnie Coffee (Address) New York City NY

15 Filed 2 7 1930 C. IRVINSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Jan 27, 1930, that I last saw h— alive on Jan 27, 1930, and that death occurred, on the date stated above, at 2 15 m.

The CAUSE OF DEATH* was as follows:

Bi lateral Lobar Pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Calvin B. LeCompte M. D.

, 19 (Address) 1113 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL 1/27 1930

20 UNDERTAKER Robt. B. Williams

ADDRESS 1518 Mt. Elliott Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 53416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 53416

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary St. 6-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Samuel E. Manson

(a) RESIDENCE NO. 2925 E. Madison St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs. Sophia Manson.

6 DATE OF BIRTH (month, day, and year) Oct 23rd 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George F. Manson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Henry Powell

(Address) Baltimore Md

15 Filed JAN 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1930, to Jan 26, 1930, that I last saw him alive on January 26, 1930 and that death occurred, on the date stated above, at 7.05 p.m.

The CAUSE OF DEATH* was as follows:

Chronic alcoholism, chronic nephritis + acute exacerbation.

(duration) 1 yrs. + mos. da.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? Refused.

What test confirmed diagnosis? Blood + urine examination

(Signed) W. M. Elgin, M. D.

1/26. 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Jan 29 1930
20 UNDERTAKER Henry W. Jenkins & Son Inc	ADDRESS Oakland Ave & Collins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53417

CERTIFICATE OF DEATH

129 E 53417

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 N. Exeter ST. 58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Salvatore Bonomo

(a) RESIDENCE NO. 432 N. Exeter ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

6a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Salvatora Bonomo

6 DATE OF BIRTH (month, day, and year) Mar 8 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Bonomo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Carmela Bonomo
(Address) 432 N. Exeter St.

15 Filed C. H. WILSON JONES, M. D. Registrar
JAN 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1929, to Jan 26, 1930, that I last saw h alive on Jan 25, 1930 and that death occurred, on the date stated above, at 5 20 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Paul Bonomo, M. D.

1/26 1930 (Address) 1663 W North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Saint Vincent

DATE OF BURIAL Jan 28 1930

20 UNDERTAKER Frank V. Pikitow

ADDRESS 270 S. Caton st

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53418

CERTIFICATE OF DEATH

3/ E 53418

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Ho 24 ST. (WARD) Bon Secours)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanislaus Burdelles

(a) RESIDENCE NO. 1502 Shamer ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Unknown

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
53		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaus Burdelles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address)

15 Filed 1 27 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1929, to Jan 25, 1930, that I last saw him alive on Jan 25, 1930, and that death occurred, an the date stated above, at 3:40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) — (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Jas. F. Hospital M. D.

19 (Address) City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary. DATE OF BURIAL Jan 28 1930

20 UNDERTAKER J. W. Bagenski ADDRESS 1930 Eastern Ave

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53419

CERTIFICATE OF DEATH

90 E 53419

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 633 St. Ann Ave St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Lyneman.

(a) RESIDENCE NO. 633 St. Ann Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Delia I. Lyneman.

6 DATE OF BIRTH (month, day, and year) The year, 1857.

7 AGE 73 Years Months Days IF LESS than 1 day hrs. or min.

72.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work U. S. R. W. Shopman.

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Richmond Va.

PARENTS

10 NAME OF FATHER John Lyneman.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va,

14 Informant C. T. Campbell.

(Address) 633 St Ann Ave

15 Filed JAN 27 1930 C. HARRISON JONES, M. D. Registrar Per DRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1929, to Jan 26, 1930 that I last saw him alive on Jan 26, 1930 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia Acidosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. W. Livezey, M. D.

, 19 (Address) 1812 W Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cathedral Cem. Date of Burial Jan 29 1930

20 UNDERTAKER E. Howard Evans ADDRESS 358 E Fort Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 27 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 53420

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53420

CERTIFICATE OF DEATH

90

REGISTERED NO. 13-54

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2306 Avalon Ave. ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Ritter.

(a) RESIDENCE NO. 2306 Avalon Ave. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 20 ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Tillie R. Ritter.

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67.	11.	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 00

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Ritter.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Louise Wagner.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany.

14 Informant Tillie R. Ritter.
(Address) 2306 Avalon St.

15 Filed ..... 19 ..... Registrar
Per

2 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Jan 26, 1930, that I last saw h-- alive on Jan 25, 1930 and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert Thomas, M. D.

Jan 27, 1930 (Address) 1166 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk. Cem. DATE OF BURIAL Jan 29 1930

20 UNDERTAKER H. Hazel Evans ADDRESS 2 E. Preston St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53421

CERTIFICATE OF DEATH

11-001 ✓ E 53421

REGISTERED NO. 24-34

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 E. Fort Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary F. Winchester.

(a) RESIDENCE NO. 121 E. Fort Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles T. Winchester.

6 DATE OF BIRTH (month, day, and year) March, 1865.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64.	10.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Belto. Md.

PARENTS

10 NAME OF FATHER Jacob Hoffman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Auburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hazel George.

(Address) 39 S. Curley St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/16, 1930, to Jan 26, 1930, that I last saw h[illegible] alive on Jan 26, 1930 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. McGuire, M. D.

1/27, 1930 (Address) 1239 Milliam N

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Jan 29 1930

20 UNDERTAKER C. Howard Evans

ADDRESS 55 S. Fulton

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53422

CERTIFICATE OF DEATH

24-801 E 53422

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1128 N. Stricker ST. (1-6-27 WARD)

2—FULL NAME Hattie Brown

(a) RESIDENCE NO. 1128 N. Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel J. Brown

6 DATE OF BIRTH (month, day, and year) Sept 7 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Troy N. C

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant David J. Brown
(Address) 1128 N. Stricker

15 Filed ..., 19 ... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25 - 30

17 I HEREBY CERTIFY, That I attended deceased from 1/25, 19 30, to 1/25, 19 30, that I last saw h alive on 1/25 - 1930 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro Cerebral Hemorrhage a Paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bruce Clutton, M. D.

1/27 1930 (Address) 213 N Stricker

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Jan 28 1930
20 UNDERTAKER	ADDRESS
Jam. W. Chase & Son	1412 Mosher

Spec.—2-29-28—L. F. S.—500 Blks.

E 53423

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-08

E 53423

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 N. Lafayette) (WARD) 16-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Letha A. Stephney

(a) RESIDENCE NO. 1626 N. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Harry Stephney

6 DATE OF BIRTH (month, day, and year): July 7 - 1901

7 AGE: Years 28 | Months 6 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Roslyn Md

PARENTS

10 NAME OF FATHER: Lloyd Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Maria Joseph

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Harry Stephney

(Address) 1626 N Lafayette

15 Filed 2 7 1930 Registrar

16 Registered 2 7 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 25/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 27 19 30 to Jan 25 19 30

that I last saw h[illegible] alive on Jan 25 19 30

and that death occurred, on the date stated above, at 12.40 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. J. Kalter M. D.

1/27 19 30 (Address) 1725 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Crematory — DATE OF BURIAL: Jan 30 19 30

20 UNDERTAKER: Wm M. Chase & Son — ADDRESS: 1400 Mad

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53124 E 53124

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 327 Lorraine Ave. 12-5 90 St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ralph B. Scott

(Residence in Baltimore: No. 327 Lorraine Ave. 54 St.; yrs. 3 mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
Male	White	Married

6-DATE OF BIRTH. October (Month) 20 (Day) 1875 (Year)

7-AGE. 54 yrs. 3 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman 066
(b) General nature of industry, business, or establishment in which employed (or employer): Horn Ice Cream Co.

9-BIRTHPLACE. (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Dr J. Henry Scott

11-BIRTHPLACE OF FATHER. (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. Isabella Brunt

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Helen May Scott

(Address) 327 Lorraine Ave.

15- Filed JAN 28 1930 192 C. HAMPSON JONES, M.D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. January (Month) 25 (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

Hemorrage of Heart

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D. (Coroner.)

1/27 1930 (Address) 2632 N Charles

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cem DATE OF BURIAL. Jan 27 1930

20-UNDERTAKER. J. J. Lucas & Son ADDRESS Baltimore

is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

St. Catherine's Hyth & Hanover

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 E 53425

E 53425

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1714 Johnson ST. (WARD) 24-34

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Manuel S. Pappas

(a) RESIDENCE NO. 1714 Johnson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 27-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Steris Pappas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Catherine Calahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Steris Pappas

(Address) 1714 Johnson Street

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan - 27 '30

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1929 to Jan 27, 1930

that I last saw h.. alive on Jan 27, 1930

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) M. H. Campbell M. D.

1/27, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery

DATE OF BURIAL: 1/28 1930

20 UNDERTAKER: William Cook

ADDRESS: 1217 S. Caul Stree

Spec.—1-12-23—M&T—500 Blks.

Ogilvie

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53426 101-001 E 53426

CERTIFICATE OF DEATH.

REGISTERED NO. 27-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2913 Northern Parkway ST. WARD

2-FULL NAME Elias Marley Ogilvie

(a) RESIDENCE NO. 2913 Northern Parkway ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Lula May Glashoff

6 DATE OF BIRTH (month, day, and year) April 27 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	33	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Manager 066

(b) General nature of industry, business, or establishment in which employed (or employer) Prints Business

(c) Name of employer Kimball Prints Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John W Ogilvie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nova Scotia Canada

12 MAIDEN NAME OF MOTHER Julia Fitzpatrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant Olivia Potts (Sister)

Address 2709 Groveland Ave

15 Filed 19 HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1929, to Jan 28, 1930, that I last saw him alive on Jan 26, 1930 and that death occurred, on the date stated above, at 1.15 a. m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ophthalmoscope

(Signed) E. M Lowe, M. D.

19 (Address) 2605 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetary — DATE OF BURIAL 1/29/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

SECTION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53427

E 53427, 90

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 76-37

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Shay

(a) RESIDENCE NO. 805 S. Fagley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hospitals

15 Registrar

MAR 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-26-30

17 I HEREBY CERTIFY, That I attended deceased from 3-2-29, 19, to 1-26-30, 19, that I last saw her alive on 1-26-30, 19, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

1-27, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 1/27/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

E 53428

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53428

CERTIFICATE OF DEATH

84

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2717 Roslyn Av St.) 15-61 (Ward)

2-FULL NAME Chas. H. Pennock.

(a) RESIDENCE NO. 2711 Elsinore Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Pennock.

6 DATE OF BIRTH (month, day, and year) Aug 3 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	59	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Asst Bkg Eastern
(b) General nature of industry, business, or establishment in which employed (or employer) Rolling Mills Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Coatsville Pa
(State or country)

PARENTS

10 NAME OF FATHER Chas E. Pennock

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Mary Evans

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Nellie Pennock
(Address) 2711 Elsinore Av

Filed JAN 28 1930 G. HAMPSON JONES, Jr. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Angina

(Signed) H. Hedrick, M. D.
Coroner
(Address) Jan 28 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

UNDERTAKER Joseph D Cook

DATE OF BURIAL Jan. 30 1930

ADDRESS 1002 N Gilmor St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53429

CERTIFICATE OF DEATH

1937

E 53429

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hosp - St. 26-37 Ward 1st)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Francis Gist

(a) RESIDENCE NO. 4803 Fleet St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) Mar 27-1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	9	29	

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Sailor 086

(b) General nature of industry, business, or establishment in which employed (or employer) Seamanship

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Henry T Gist

11 BIRTHPLACE OF FATHER (city or town)

(State or country) York Pa

12 MAIDEN NAME OF MOTHER Mary L. Evans

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Harvey Gist

(Address) 4803 Fleet St.

15 Filed 1937 C. HARRY JONES, Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: While walking along road was run down by speeding automobile. Hom.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull + Fract leg

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eastern Av Rd + 46th St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J J Frame, M. D.

1/27, 1930 (Address) 2129 Mt Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL Jan 29 1930

20 UNDERTAKER John Mc Neal — ADDRESS 200 Chase

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53430

E 53430

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3916 Elm ave St. 13-52 (Ward)

2-FULL NAME Anna M. Brooks

(a) RESIDENCE NO. 3916 Elm ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16 1929.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	0	3.	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. city
(State or country) Md.

PARENTS

10 NAME OF FATHER Arthur H. Brooks

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna J. Harmon.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Anna Brooks.
(Address) 3916 Elm ave.

15 Filed ... 1930 HAMPSON JONES, M. D. Registrar

By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan. 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and from (autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Cachexia

Contributory Syphilis (duration) yrs. mos. 7 ds.

Contributory (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis? Syphilis

(Signed) J. C. Slade, M. D.

(Address) 1431 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem Hyattsville	1/29 1930

20 UNDERTAKER Walter Davis 330 N Paca st

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 53431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 53431

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Shore, Cabin Branch, Curtis Bay St.) 25-77 (Ward)

2-FULL NAME John Rooney.

(a) RESIDENCE NO. Shore, Cabin Branch, Curtis Bay. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	58	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Rooney.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Mrs. Jack Flood.
(Address) Brooklyn, A. A. Co. Md.

15 Filed ..., 19... THOMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 26, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage
Due to ulcerated Carcinoma of the Oesophagus.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry.

(Signed) Otto A. Bernhardt, M. D.

1/27 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross R.C.	1/28 1930
20 UNDERTAKER J. J. Fahey & Son	ADDRESS 1318 Eighth

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-28-1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53432

CERTIFICATE OF DEATH

90 E 53132

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3104 Chestnut Avenue St., 13-51 Ward)

2-FULL NAME Frank Boardman

(a) RESIDENCE NO. 3104 Chestnut Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND (or) WIFE of Leonie V. Boardman

6 DATE OF BIRTH (month, day, and year) Nov. 20 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ... or ...
	59	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paper Hanger
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Oakland Md
(State or country)

PARENTS

10 NAME OF FATHER Francis E. Boardman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Conn

12 MAIDEN NAME OF MOTHER Matilda Whalen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Howard Co Md

14 Informant Mrs Leonie V. Boardman
(Address) 3104 Chestnut Ave

15 Filed ..., 19.. THOMPSON JONES, M. D. Registrar

JAN 28 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonar Hemorrhage
Disease of Heart

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

1/26 1930 (Address) 3532 Boulevard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Jan 28 1930
20 UNDERTAKER John O Mitchell Son	ADDRESS 1900 Eutaw Place

Spec.—8-16-29—L. F. S.—100 Bks.

ROESLER 8-002

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53433

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 816 WARD)

REGISTERED NO. E 53433

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herman Roesler Jr

(a) RESIDENCE NO. 2629 E. Oliver ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel M. Roesler

6 DATE OF BIRTH (month, day, and year) Feb. 1/1899

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police 061

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Herman Roesler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Elizabeth Twist

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Ethel M. Roesler

(Address) 2629 E. Oliver St

15 Filed JAN 28 1930 STAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/28/30

17 I HEREBY CERTIFY, That I attended deceased from January 20, 1930 to January 28, 1930, that I last saw h alive on January 28, 1930 and that death occurred, on the date stated above, at 9 40 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) Post operative Shock

Cardiac failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/23/30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) David Seiver, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem DATE OF BURIAL Jan 28 1930

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53434

E 53434

CERTIFICATE OF DEATH

1—PLACE OF DEATH Hospital for the Women of Maryland

REGISTERED NO. 74

CITY OF BALTIMORE: (No. Lafayette and John ST., 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Margaret [illegible] Tiffin

(a) RESIDENCE NO. 3201 Fraser ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Edward Tiffin.

6 DATE OF BIRTH (month, day, and year) August 15, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Ford County, Maryland

PARENTS

10 NAME OF FATHER William Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Rainsdon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs. Laura Tiffin

(Address) 3201 Fraser Street.

Filed 2 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28, 1930

17

I HEREBY CERTIFY, That I attended deceased from December 30, 1929, to January 28, 1930,

that I last saw her alive on January 28, 1930

and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Earle P. Clemson, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edmondson Ave.

DATE OF BURIAL Jan 30 1930

20 UNDERTAKER Geo. H. Little

ADDRESS 2 E Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53435 31 E 53435

E 53435

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2226 Jefferson St. 7-10 Ward)

2-FULL NAME Celia Simon

(a) RESIDENCE NO. 2226 Jefferson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	23	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Simon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis (Undertaker)
(Address)

Filed JAN 28 1930 19 HARRISON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulm Hemorrhage

Pulmonary Tuberchlosis

(Treated at T.B. Sanatorium at Reistertown) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Watts, M. D.

1/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel — DATE OF BURIAL 1/28 19 30

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blm.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53436

CERTIFICATE OF DEATH

3 1 ✓ E 53436

1—PLACE OF DEATH Baltimore City Hospitals (Dc. 17-24) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lottie Gales

(a) RESIDENCE NO. 579 W. Hoffman st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Gales

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Virginia

PARENTS

10 NAME OF FATHER Milton Richardson

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Ann Fortune

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address)

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930, to Jan. 26, 1930, that I last saw her alive on Jan. 26, 1930 and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas Thurnell M. D.

1-27 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 1/29 1930

20 UNDERTAKER Samuel Wensley ADDRESS 578 Pine

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53437 — CERTIFICATE OF DEATH — 3 ✓ E 53437

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO. 4325

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Thomas

(a) RESIDENCE NO. 659 Fairmount ave. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marian

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Guano factory

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 086

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Fred Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mo.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 Filed JAN 28 1930 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1929, to Jan. 26, 1930, that I last saw him alive on Jan. 26, 1930 and that death occurred, on the date stated above, at 9.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculous meningitis (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas Thomas M.D.

1-27, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 1/28 1930

20 UNDERTAKER Samuel I Newsley

ADDRESS 538 N Bridle

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53438

E 53438

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 15-21 Ward)

2-FULL NAME Levi S. Hurdle

(a) RESIDENCE NO. 1704 Westwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Hardle

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Agent.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) La.
(State or country)

PARENTS

10 NAME OF FATHER Levi Hurdle

11 BIRTHPLACE OF FATHER (city or town) La.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Annie Hurdle
(Address) 1704 Westwood

15 Filed [illegible] 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or [illegible]) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer.

Sudden (duration) yrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) H. Leslie Pinckard M. D.

Jan 26th 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 1/28 1930

20 UNDERTAKER Samuel T. Newsley

ADDRESS 78 Bell

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

[illegible] JAMES H. WILSON JONES, M. D.

Ref

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53439

CERTIFICATE OF DEATH

3N E 53439

REGISTERED NO.

E 53439

1-PLACE OF DEATH

City of BALTIMORE: (No. 3105 Westwood Ave St. 15-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Taylor Thomson

(a) RESIDENCE NO. 3105 Westwood Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. 20 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Howard B. Thomson

6 DATE OF BIRTH (month, day, and year) June 6th 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	48	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home White

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (City or town) Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Hefflin

13 BIRTHPLACE OF MOTHER (city or town) Balto Md

(State or country)

14 Informant Jane Bernadette Janaen

(Address) 2304 N Lanvale St

15 Filed C. HARRISON JONES, M. D. Registrar

By LMG

N 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1930

I HEREBY CERTIFY, That I attended deceased from July 29, 1929 to Jan 26, 1930

that I last saw h[illegible] alive on Jan 26, 1930

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 1C ds.

CONTRIBUTORY Pulmonary Tuberculosis

(Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter Flowers, M. D.

1/28/30 (Address) 929 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial: Jan 29 1930

20 UNDERTAKER E. Carson Kennard

ADDRESS 723 W. Lafayette Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

E 53440

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53440

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3405 Lake Montebello Ave. (WARD) Five

2-FULL NAME Charles Richard Sprates

(a) RESIDENCE No. 3405 Lake Montebello WARD Five

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Esther Sprates

6 DATE OF BIRTH (month, day, and year) March 25 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood worker

(b) General nature of industry, business, or establishment in which employed (or employer) Morgan Mill Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard P Sprates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret P Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Esther Sprates

(Address) 3405 Lake Montebello Ave

15 Filed JAN 28 1930 19 C. HAMPSON JONES, M. D. Registrar

By Lilly

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-26 1930

17 I HEREBY CERTIFY, That I attended deceased from April 29 1929 to Jan 26 1930,

that I last saw him alive on Jan 25 1930,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

Jan 29 1930 (Address) 1834 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Jan 30 1930
UNDERTAKER	ADDRESS
Josiah Syfer	1600 N Howard ave

HON is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53441

CERTIFICATE OF DEATH

90

E 53441

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1632 John St. 14-20)

2-FULL NAME Isabella Huey McIntyre

(a) RESIDENCE NO. 1632 John St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. - mos. - ds. How long in U. S., if of foreign birth? - yrs. - mos. - ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Michael McIntyre

6 DATE OF BIRTH (month, day, and year) ------ 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	75	--	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Penn.

PARENTS

10 NAME OF FATHER Robert Huey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth McMann

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or country) Penn.

14 Informant Miss Mary Belle McIntyre
(Address) 1632 John Street

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. H. Leuch, M. D.

1/30/30 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	1/29 19 30

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53442 | CERTIFICATE OF DEATH | 129 E 53442

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 8247 Modena ST., 7-12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph J Herx

(a) RESIDENCE NO. 8247 Modena ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Wht | 5 Single, Married, Widowed, or Divorced, (write this word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 3 1876

7 AGE: Years 53 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 083

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Herx

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Marie Herx (Address) 824 Modena

15 Filed JAN 28 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 30

I HEREBY CERTIFY, That I attended deceased from Nov 3 1929, to Jan 26 1930, 19..

that I last saw alive on Jan 26, 1930

and that death occurred, on the date stated above, at 9.45 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Grauer M.D.

Jan 28 1930 (Address) 806 N. Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 31 1930

20 UNDERTAKER Ernest Broccolini Inc 1906 — ADDRESS Baltimore

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53443

E 53443

CERTIFICATE OF DEATH

REGISTERED NO. 66

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 13 ST., WARD)

2—FULL NAME Frank Gurkouski (Jurkowski)

(a) RESIDENCE NO. 807 S. Belnord Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Jurkowski) Mamie Gurkouski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. (Jurkowski)

PARENTS

10 NAME OF FATHER Tom Gurkouski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Dora Sajdak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records of Baltimore City Hospitals (Address)

15 Filed C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27-30

17 I HEREBY CERTIFY, That I attended deceased from 1-24-30, 19..., to 1-27-30, 19..., that I last saw him alive on 1-27-30, 19..., and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH* was as follows:

Alcoholism, chronic & acute

(duration) yrs. 7 mos. da.

CONTRIBUTORY (Secondary) Delerium Tremens

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

1-27, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus DATE OF BURIAL Jan 30 1930

20 UNDERTAKER J W Bazenski ADDRESS

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53144 E 53144

38

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14-20 ST. WARD)

2—FULL NAME Albert Fennell

(a) RESIDENCE NO. 570 Wilson St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Fennell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Fennell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Branche ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hospitals

FEB 3 1930

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27-30

17 I HEREBY CERTIFY, That I attended deceased from 1-21-30, 19..., to 1-27-30, 19...,

that I last saw h... 1m alive on 1-27-30, 19...

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, left — 11 days

(over)

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

1-27, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 1-29 1930

UNDERTAKER Lewis Easter

ADDRESS 816 Park Ave

Spec.—2-19-28—L. F. S.—500 Blks.

E 53445 ✓ E 53445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Sinclair Lane ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edith Evelyn Johnson

(a) RESIDENCE NO. 2011 Sinclair Lane ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 1 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of J. Frank Johnson

6 DATE OF BIRTH (month, day, and year) Dec 18th 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	31	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Albert C Taylor

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Ogle

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Mrs H Kiss

(Address) 623 N Montford ave

15 Filed JAN 28 1930 HENDERSON JONES, Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1930 to Jan 26 1930

that I last saw h[illegible] alive on Jan 25 1930 and that death occurred, on the date stated above, at 11[illegible] a m.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hall. W White M. D.

1/27. 1930 (Address) 2600 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery DATE OF BURIAL Jan 29th 1930

20 UNDERTAKER George Schilling & Sons ADDRESS 1126 E Monument st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53446

CERTIFICATE OF DEATH

1 32

E 53446

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Rothe

(a) RESIDENCE NO. Philadelphia Road ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced DUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 11-1883 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Hand

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Rothe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed 2 6 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27-30

17 I HEREBY CERTIFY, That I attended deceased from 11-23, 1929, to 1-27, 1930, that I last saw h[er] alive on 1-27, 1930 and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

Urethral Calculus

Urethral fistula

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 1-9-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. U. Pumphrey, M. D.

1-27, 1930 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL First Evang. Cemetery

DATE OF BURIAL Jan 30 1930

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager st

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53447

E 53447

CERTIFICATE OF DEATH.

161

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4065 Vincent ST. 19-28 (WARD)

2-FULL NAME Miscarriage - Lawhon

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	N	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/25/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... —

(b) General nature of industry, business, or establishment in which employed (or employer) ..... do

(c) Name of employer

9 BIRTHPLACE (city or town) 4065 Vincent St
(State or country)

PARENTS

10 NAME OF FATHER Jack Lawhon

11 BIRTHPLACE OF FATHER (city or town) Smith Carolina
(State or country)

12 MAIDEN NAME OF MOTHER Agatha Bevans

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Parents
(Address)

15 Filed 1-28 1930 C. HAMPSON JONES
1299 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/25/ 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/25, 1930, to 1/25, 1930,
that I last saw h[illegible] alive on 1/25, 1930,
and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Miscarriage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Signs & Symptoms

(Signed) Henry N Dutrow, M. D.

19 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: JAN 27 1930

20 UNDERTAKER [illegible] Director Health.

ADDRESS

CAUSE OF DEATH MUST BE FILLED IN BY PHYSICIAN, IF POSSIBLE. EXACT STATEMENT OF CAUSE OF DEATH IS very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53448

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53448

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 17-35

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Parker Mack

(a) RESIDENCE NO. 638 W. Mulberry st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unkn. ow yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
29	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Nathan Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records

(Address) UNIVERSITY OF MARYLAND

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1929, to Jan. 19, 1930, that I last saw him alive on Jan. 19, 1930 and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thos. Jones M. D.

1-20-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER Commissioner Health

DATE OF BURIAL 19

ADDRESS JAN 27 1930

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53449 129 E 53449

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 34 WARD)

2—FULL NAME William Gibson

(a) RESIDENCE NO. 250 S. Spring ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? da. How long in U. S., if foreign birth? — yrs. — mos. — da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hospitals

15 1 28 1930, 19 C. HAMPSON JONES (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-24-30

17 I HEREBY CERTIFY, That I attended deceased from 1-15-30, 19..., to 1-24-30, 19..., that I last saw him alive on 1-24-30, 19..., and that death occurred, on the date stated above, at 3:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

(duration) ... yrs. 1½ mos. ... da.

CONTRIBUTORY (Secondary) Nephritis, Chronic; Hypertension ?

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Ft Clinical

(Signed) Marvin M. McLean, M. D.

1-25, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL ... 19...

20 UNDERTAKER Commissioner Health

ADDRESS JAN 27 1930

Spec. 2-29-28—L. F. S.—500 Blks.

E 53450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-09 53450

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Shelter ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Woodson

(a) RESIDENCE NO. 907 Shelter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 23-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby food

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Howard Woodson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mabel Shepherd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant Mabel Shepherd

(Address) 907 Shelter

Filed JAN 28 1930, 19 HARRISON SMITH

1304 RM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 19 30, to Jan 26, 19 30, that I last saw h alive on Jan 26, 19 30 and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Premature Delivery

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Jan 26, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

20 UNDERTAKER Commissioner Health

ADDRESS

DATE OF BURIAL 19

JAN 27 1930

Spec.—1-12-23—M&T—500 Blks.

E 53451

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2342 Frederick St.) (WARD) 70-64

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Cragg

(a) RESIDENCE NO. 2342 Frederick St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1/26-30

7 AGE Years Months Days If LESS than 1 day 17 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Raymond Cragg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna M Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant

(Address)

Filed 2 8 1930, 19 4305 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27- 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/26- 1930 to 1/27- 1930

that I last saw h alive on 1/27- 1930

and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Postmortem

(Signed) Chas A Cragg M. D.

(Address) 2145 N Bklt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JAN 27 1930

ADDRESS

20 UNDERTAKER Commissioner Health.

ADDRESS

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53452

161-001 ✓ E 53452

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Marzinski

(a) RESIDENCE NO. 2110 Eden St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 20, 1930

7 AGE Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Leon Marzinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Pajorski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant H. L. Douglas

(Address) Johns Hopkins Hospital

15 Filed 2-8-1930 19 Per C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-20, 1930, to 1-20, 1930, that I last saw him alive on 1-20, 1930 and that death occurred, on the date stated above, at 9.00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. L. Douglas, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JAN 28 1930

Spec.—8-18-29—L. F. S.—100 Bks.

2 3326 E 53453

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 3326 E 53453

CERTIFICATE OF DEATH

161-00 E 53453

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Wilkes

(a) RESIDENCE NO. 933 E. Preston ST., St— WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 21-30

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child - boo

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md -

PARENTS

10 NAME OF FATHER: Harry Wilkes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md -

12 MAIDEN NAME OF MOTHER: Helen Greenman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md -

14 Informant: Records —

(Address) JOHNS HOPKINS HOSPITAL (JOHNS HOPKINS HOSPITAL)

15 Filed , 19 C. HAMPSON JONES, M. D.

4308 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 22-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to Jan 22, 1930, that I last saw him alive on Jan 22, 1930 and that death occurred, on the date stated above, at 1.45 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. W. Bickford Jr., M. D.

1/26/1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health

JAN 28 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53454

100-001 ✓ E 53454

CERTIFICATE OF DEATH

1—PLACE OF DEATH South Baltimore Gen. Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ... St. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Captain Frank Dowden

(a) RESIDENCE NO. 814 E. Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaretha Dowden

6 DATE OF BIRTH (month, day, and year) ? 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
88-101				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retard

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frank Dowden

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Hosp record
(Address)

15 1-28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27-30

17 I HEREBY CERTIFY, That I attended deceased from 1-23-30, 19..., to 1-27, 19 30, that I last saw h. alive on 1-27, 19 30 and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho. Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Generalized arterio - Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs.

(Signed) Joseph Labkaitis M. D.

19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Jan 30 1930
20 UNDERTAKER	ADDRESS
M. W. E. Deppe & Son	521 Cross St

Cor.—10-10-29—A Co.—100 Bks.

SAFRON ZILTKOW

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53155

CERTIFICATE OF DEATH

167-001

E 53155

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1532 E Pratt St., 6-9 Ward)

2-FULL NAME Safron Ziltkow

(a) RESIDENCE NO. 1532 E Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lehy Ziltkow

6 DATE OF BIRTH (month, day, and year) Nov 13 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	49	2	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Alex Ziltkow

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Lehy Ziltkow
(Address) 1532 E Pratt

15 Filed JAN 28 1930 C. HILLSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide
Ill Gas Poisoning
Asphyxia
(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?
Jan 27 1930
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis? By Ex
(Signed) G C Eliades M. D.
, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Cem	Jan 29 1930

20 UNDERTAKER M W E Hupp ADDRESS 832 S Ann

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53456 233381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 60-002 E 53456

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Raymond M Tong

(a) RESIDENCE NO. Globe, Arizona ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	2	16 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Arizona

PARENTS

10 NAME OF FATHER A M Tong

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Esmeralda Maston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant James Alfred Records Tong

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19 ... Registrar

28 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27-30

17

I HEREBY CERTIFY, That I attended deceased from 1/24, 1930, to 1/27, 1930, that I last saw h[illegible] alive on 1/27, 1930 and that death occurred, on the date stated above, at 11:40 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Hypothyroidism

(duration) ... yrs. 10 mos. ... da.

18 Where was disease contracted if not at place of death? Arizona

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood chem. exam.

(Signed) W. S. Muncie, M. D.

1/27, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lucron Arizona	1/28, 30
20 UNDERTAKER Henry W. Jenkins' Son Co	ADDRESS Richard Mc Cullough

Spec.—2-29-28—L. F. S.—500 Blks.

E 53457

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 53457

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 1-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie Green

(a) RESIDENCE NO. 1413 W. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of T. J. Green

6 DATE OF BIRTH (month, day, and year) July 28, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Thomas Alves

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Katherine Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Albert Hathaway

(Address) 1413 W. Fayette St

15 Filed JAN 28 1930 C. HAMPSON JONES, M. D. Registrar

Reg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1930, to Jan 27, 1930, that I last saw her alive on Jan 27, 1930 and that death occurred, on the date stated above, at 2 50 P m.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas

Etiology unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

1/28, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Jan 29 1930

20 UNDERTAKER J. B. Tapper ADDRESS 858 W. Balto St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53458

188-009 53458

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

University Hospital 4-30 (Ward)

City of Baltimore: (No.

2-FULL NAME Joseph A. Klema,

(a) RESIDENCE NO. Elkridge, Maryland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1918

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	12	3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Elkridge
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Klema

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Harriett Dowling

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Frank Klema
(Address) Elkridge, Md.

Filed 1-28 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28, 1930. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Kidney. (Right.)
Accidental Death.
Coasting down hill and struck Mail Box. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage. Shock.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Elkridge, Md.
Did an operation precede death? Yes Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Eugene Zellers M. D.
1/28. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge, Md.	Jan. 30, 19

20 UNDERTAKER	ADDRESS
E. Leroy Stiffler, Inc.	125 E North ave.

E. Leroy Stiffler, Inc.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53459

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53459

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Mathews

(a) RESIDENCE NO. 110 Shipley Ave. Catonsville (WARD)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dr. West.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

JAN 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/28/30.

17 I HEREBY CERTIFY, That I attended deceased from 1/18, 1930, to 1/28, 1930, that I last saw him alive on 1/28, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Generalized Peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/18/30

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical symptoms

(Signed) George Yeager, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cem. DATE OF BURIAL Jan 31 1930

20 UNDERTAKER Euston Son ADDRESS Ellicott City

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53460

CERTIFICATE OF DEATH

172 E 53460

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2775 Alameda St., 9-46 Ward)

2-FULL NAME William Harry Murr

(a) RESIDENCE NO. 2777 Alameda St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Elliott Murr

6 DATE OF BIRTH (month, day, and year) Dec 28/1869

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	60	0	29 28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particolar kind of work Asst. Supt.
(b) General nature of industry, business, or establishment in which employed (or employer) Parcel Post
(c) Name of employer U. S. Mail

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Murr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER MaryHarrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Clara Elliott Murr (wife)
(Address) 2777 Alameda

15 Filed ... C. HAMPSON JONES, M. D. Registrar

1 28 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 20/30 [19]32

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed Skull- Leaped from 2nd story porch to cement pavement. (Suicide)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Melancholia

(doration) ... yrs. ... mos. ? ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..., M. D.

1/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL Jan. 29 1930

20 UNDERTAKER Margaret G. Flynn — ADDRESS 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53461

E 53461

CERTIFICATE OF DEATH

101-08

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Phillip Scott

North Side Dormitory

(a) RESIDENCE NO. Sparrow's Point, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma Scott

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER James Scott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Eliza McGee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Robt E. Williams
(Address) 1515 McElderry St

FEB 2 1930 C. HAMPSON JOHNS, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to h is death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia Bilateral
(Lower Lobes)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at Sparro Pt, Md.

Did an operation precede death? no Date of

Was there an autopsy? Yes at Hopkins Hosp.

What test confirmed diagnosis?

(Signed) [signature], M. D.

1/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	Jan 29 1930
20 UNDERTAKER	ADDRESS
Robt E Williams	1515 McElderry St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

B 353774 B 353462

HEALTH DEPARTMENT—CITY OF BALTIMORE

29 E 53462

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) (WARD) 25-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leroy Redmond

(a) RESIDENCE NO. 2425 Pacas St (ST.) Mt Winans Md (WARD)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced (or) WIFE of Elzina

6 DATE OF BIRTH (month, day, and year) Jan - 15 - 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car

12 MAIDEN NAME OF MOTHER Sarah Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan - 26 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1930, to Jan 26, 1930, that I last saw him alive on Jan 26, 1930, and that death occurred, on the date stated above, at 3:15 A m.

The CAUSE OF DEATH* was as follows:

Tetanus

(duration) — yrs. — mos. 5 da.

CONTRIBUTORY (Secondary) 34
The Spine. The Ankle (duration) — yrs. 6 mos. — da.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? Yes Date of 1.12.30 & 1.23.30

Was there an autopsy? Yes.

What test confirmed diagnosis? Cultures - Path. Specimen.

(Signed) Johns Hopkins, M. D.

1/26 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem. DATE OF BURIAL Jan 29 1930

UNDERTAKER Robert F. Walker ADDRESS 1540 Eutaw St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53463

E 53463

CERTIFICATE OF DEATH

31

REGISTERED NO. 15-22

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 Wholeboat ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Wesley Gurley

(a) RESIDENCE NO. 1340 Wholeboat ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ann Gurley

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) Hemp-Tyler Lumber Co

(c) Name of employer Calvert Co Md

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md

PARENTS

10 NAME OF FATHER John Wesley Gurley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co

12 MAIDEN NAME OF MOTHER Rachel Ann Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Mary Ann Gurley

(Address) 1340 Wholeboat St

15 Filed 1 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25, 1930

17 I HEREBY CERTIFY That I attended deceased from June 10, 1929 to Jan 25 1930

that I last saw h alive on Jan 24, 1930

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonic Tuberculosis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

Bed Sores

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No

Was there an autopsy? Yes - Dr Malders

What test confirmed diagnosis? Physical

(Signed) Wm. H. Wright, M. D.

1/28, 1930 (Address) 1209 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friendship Calvert Co Md.

DATE OF BURIAL Jan 29 1930

20 UNDERTAKER Thomas G. Kelson.

ADDRESS 1303 Presstman St.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

S. J Walker Thomas Carolina ST
1228 N

E 53464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 53464

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 E. North Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Roberts

(a) RESIDENCE NO. 1309 E. North Ave ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Luthers Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Fredericka Rochester

(Address) 1309 E North Ave

15 [illegible] HAMPSON JONES, M.D.

19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to Jan 28, 1930, that I last saw h alive on Jan 28, 1930 and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure of Compensation

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter Stevens M. D.

July 29 1930 (Address) 1228 N Caroline St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 1/31/1930

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53165 | 46 E 53165

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2726 Lamont Place ST., 4-46 WARD)

2-FULL NAME Martha A. Marrow

(a) RESIDENCE No. 503 E. 30th St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Henry L. Marrow

6 DATE OF BIRTH (month, day, and year) Oct 18 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
43	42	3	9	

8 OCCUPATION OF DECEASED at home

(a) Trade, profession or particular kind of work housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) S. Carolina
(State or country)

PARENTS

10 NAME OF FATHER James Hickson

11 BIRTHPLACE OF FATHER (city or town) S C
(State or country)

12 MAIDEN NAME OF MOTHER Dora Hickson

13 BIRTHPLACE OF MOTHER (city or town) S C
(State or country)

14 Informant Henry L. Marrow
(Address) 503 E. 30th St

15 Filed ..... 19 ..... By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to Jan 27, 1930.

that I last saw her alive on Jan 27, 1930,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY (Secondary) Uterine Carcinoma

(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted —
if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) L. L. Grady M. D.

1-28 1930 (Address) 4218 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL 1/30 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUTION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 53466 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53466

CERTIFICATE OF DEATH.

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1332 James St. Ward) 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Ella Deems

(a) Residence No. 1332 James St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced ~~HUSBAND of~~ (or)-WIFE of Thomas E Deems

6-DATE OF BIRTH (month, day and year) Oct. 24, 1862

7-AGE. 67 yrs. 3 mos. 4 ds. If less than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work housework

(b) General nature of indnstry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Balto., Md.

PARENTS.

10-NAME OF FATHER. Charles Sapp.

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Balto., Md.

12-MAIDEN NAME OF MOTHER. Alice Parsons

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Balto., Md.

14- (Informant) Anna King

(Address) 1339 James St

15- Filed ... 19?

C. HAMPSON JONES, M. D.
Registrar.

AUG 29 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan. 28, 1930

17- I HEREBY CERTIFY, That I attended deceased from Jan. 24 1930 to Jan. 28 1930

that I last saw h.er alive on Jan 27 1930

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

auricular fibrillation

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) terminal pneumonia

(Duration) ....yrs. ....mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual tests.

(Signed) Geo. A. Kinipp, M. D.

, 19 (Address) 3035 Edmondson

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	1/30/ 19.30

20-UNDERTAKER.	ADDRESS
Wm Cook	1217 St Paul St

In plain terms, so that it may be properly classified. Entries must be complete in accordance with instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53467 ✓ E 53467

CERTIFICATE OF DEATH

E 53467 31

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 21-29 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lula White

(a) RESIDENCE NO. 1354 Cleveland St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John White

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Benjamin Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lizzie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hospitals

15 Date Received JAN 29 1930 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-26-30

17 I HEREBY CERTIFY, That I attended deceased from 1-24-30, 19..., to 1-26-30, 19..., that I last saw her alive on 1-26-30, 19..., and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs, Intestine & Abdominal Glands

(duration) ? yrs. mos. da.

CONTRIBUTORY (Secondary) Myocarditis, Chronic Nephritis (duration) yrs. 4 mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Marvin W. McLean, M. D.

1-27, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Alburn Cmty

UNDERTAKER Walter B. Spriggs

DATE OF BURIAL 1/29 1930

ADDRESS 859 Bramley St

important. See instructions on back of certificate.

(Lewis Skirven)

Spec.–7-17-26—A Co.—200 Bks.

E 53468

HEALTH DEPARTMENT—CITY OF BALTIMORE

+129 E 53468

CERTIFICATE OF DEATH

1-PLACE OF DEATH Md. General Hospital REGISTERED NO.

City of BALTIMORE: (No. 11-24 St Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Lewis Skirven

(a) RESIDENCE NO. Chestertown Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lewis Mrs. Lewis Skirven

6 DATE OF BIRTH (month, day, and year) Dec. 19th 1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rock Hall, Md

(State or country)

PARENTS

10 NAME OF FATHER J. Walter Skirven

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Hailton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Hospital Records

(Address)

15 FILED JAN 29 1930 16 C. HANSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/28 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/13, 1930, to 1/28, 1930.

that I last saw h~~im~~ alive on 1/28, 1930,

and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Cardio - vascular - Renal disease

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY Pulmonary edema

(Secondary)

(duration) yrs. mos. 15 ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Md. Date of Burial Jan 30 1930

20 UNDERTAKER John O Mitchell & Sons ADDRESS 1900 Eastern Ave

Plan

(Lewis Skirven)

Spec.–7-17-26—A Co.—200 Bks.

E 53468

HEALTH DEPARTMENT—CITY OF BALTIMORE

+129 E 53468

CERTIFICATE OF DEATH

1-PLACE OF DEATH Md. General Hospital REGISTERED NO.

City of BALTIMORE: (No. 11-24 St Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Lewis Skirven

(a) RESIDENCE NO. Chestertown Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. 6 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lewis Mrs. Lewis Skirven

6 DATE OF BIRTH (month, day, and year) Dec. 19th 1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rock Hall, Md

(State or country)

PARENTS

10 NAME OF FATHER J. Walter Skirven

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Hailton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Hospital Records

(Address)

15 FILED JAN 29 1930 16 C. HANSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/28 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/13, 1930, to 1/28, 1930.

that I last saw h~~im~~ alive on 1/28, 1930,

and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Cardio - vascular - Renal disease

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY Pulmonary edema

(Secondary)

(duration) yrs. mos. 15 ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Md. Date of Burial Jan 30 1930

20 UNDERTAKER John O Mitchell & Sons ADDRESS 1900 Eastern Ave

Plan

tion should be carefully supplied. AGE should be stated EXACTLY. Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53469 57 ✓ E 53469

CERTIFICATE OF DEATH

REGISTERED NO. 28-65

1—PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Jones

(a) RESIDENCE NO. 8 Biddle Ed ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Britton Jones

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work cook 071

(b) General nature of industry, business, or establishment in which employed (or employer) Cook

(c) Name of employer Wm Rogers Bay

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Edward Page

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Caroline Bolden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Agnus Madison

(Address) 1817 Maryland Ave

Filed JAN 29 1930, 19 Harrison Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-27-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 27, 1930

that I last saw h[illegible] alive on Jan 27, 1930

and that death occurred, on the date stated above, at 8 20 [illegible].m.

The CAUSE OF DEATH* was as follows:

Empyema left chest

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) about yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of -

Was there an autopsy? yes

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Va.

DATE OF BURIAL 1-29 1930

20 UNDERTAKER Byron Wright

ADDRESS 1218 McElderry St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 53470

CERTIFICATE OF DEATH

E 53470

REGISTERED NO. 24-33

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 441 E Grindall St. (Ward) 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Abbott.

(a) RESIDENCE NO. 441 E Grindall St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: George Abbott

6 DATE OF BIRTH (month, day, and year): Feb. 14

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: at home

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Jeage Booth.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Anne McCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Joseph Booth.

(Address) 441 Grindall St

15 Filed Jan 29 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 20, 1930, to Jany 27, 1930, that I last saw he alive on Jany 27, 1930 and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Coupous Pneumonia

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) W. S. Smith, M. D.

Jany 29 1930 (Address) 129 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cath.

DATE OF BURIAL: 1-31 1930

20 UNDERTAKER: E. B. Harle

ADDRESS: 115 E West St.

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53471 — CERTIFICATE OF DEATH. — X 101-001 — E 53471

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1208 E. Fayette St. 5-8 WARD)

2-FULL NAME Grace Bryant

(a) RESIDENCE. No. 1208 E. Fayette ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 9 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	19	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER Ab Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Minnie Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Ofie Bryant (Address) 1208 E. Fayette st

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930, to Jan 26, 1930, that I last saw him alive on Jan 25, 1930, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Coleman M. D.

Address 2032 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Raleigh N. C — DATE OF BURIAL: Jan 28 1930

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 53472 ✓ E 53472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1146 Myrtle Ave ~~ST.~~ 17-24 ~~WARD~~

2-FULL NAME Rosa Gresham

(a) RESIDENCE NO. 1146 Myrtle Ave ~~ST.~~ WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Roya Gresham

6 DATE OF BIRTH (month, day, and year) March 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	71	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired ~~pd~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER J. Eskridge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Rosa Thompson

(Address) 1142 Myrtle Ave

15 Filed ..... 19 ..... H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 1929, to Jan 26, 1930,

that I last saw her alive on Jan 26, 1930,

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Fat acute nephritis

(duration) yrs. 1 mos. ..... da.

CONTRIBUTORY (Secondary) A doubt exists

(duration) yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. Lee Gill, M. D.

1/25, 1930 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL 1/29/1930

20 UNDERTAKER Jos. Geo. H. Holland & Son

ADDRESS Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53173 44 ✓ E 53173

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429-E. Fayette St. ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abraham Hecker

(a) RESIDENCE NO. 1429-E. Fayette St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Male	White	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mincha Hecker

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Hecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Sollodoff

(Address) 1429 E. Fayette St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/27/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1929, to Jan 27, 1930, that I last saw him alive on Jan 27, 1930, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Stomach)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Thrombosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, X. Ray

(Signed) M. Bayless, M. D.

1/29, 1930 (Address) 2040 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 1/29 1930

20 UNDERTAKER Jacob Lewis

ADDRESS 1439 E. Baltimore

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bkn.

E 53174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 53174

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 Forest St.) 10-14 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella Cullen

(a) RESIDENCE No. 731 Forest ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: Charles C. Cullen

6 DATE OF BIRTH (month, day, and year): not known

7 AGE: Years: about 61 yrs | Months: | Days: | If LESS than 1 day, hrs. or ..... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife at Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James Duffy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs Mary Williams

(Address): 3114 E Monument Ave

15 Filed: JAN 29 1930 C. HAMPSON JONES, M. D. Registrar

P.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan - 1 - 1930, to Jan 27, 1930, that I last saw her alive on Jan 26, 1930, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

History was (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Klein, M. D.

1-27, 1930 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. | DATE OF BURIAL: June 30, 30

20 UNDERTAKER: Elmer W. Conklin | ADDRESS: 924 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53475 90 E 53475

CERTIFICATE OF DEATH

E 53475

REGISTERED NO. 26-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5319 Eastern ave ST., 26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine E. Kuhn

(a) RESIDENCE NO. 5319 Eastern ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 9th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Gov

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Eduard T. Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna M. Heuz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Thos. E. Eckhardt.

(Address) 5319 Eastern ave.

15 Filed JAN 29 1930 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 26th 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Jan 26, 1930.

that I last saw h-er alive on Jan 25 1930

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephrocarditis

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B Tilson M. D.

1/27. 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Jan 29th 1930
20 UNDERTAKER: D. Lilly & Sons Inc.	ADDRESS: 400 S. Wolfe St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53476

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53476

47v

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 20 N. 20-th ST. 12-51 WARD)

2—FULL NAME Joseph P. McFarland

(a) RESIDENCE NO. 20 N. 20-th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna McKeown

6 DATE OF BIRTH (month, day, and year) 1-11-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	—	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 059

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John McFarland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. J. McFarland

(Address) 20 N. 20-th St

15 JAN 29 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-20, 1930, to 1-27, 1930, that I last saw him alive on 1-26, 1930 and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Thrust signs

(Signed) A. J. Cundy M. D.

1929 (Address) 320 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Jan 30 1930
UNDERTAKER	ADDRESS
Geo. W. Wedefeld	501 E 22nd St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53477

CERTIFICATE OF DEATH

REGISTERED NO. E 53477

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH City Hospital

City of Baltimore: (No. 1-24 St. Ward)

2-FULL NAME Robt Ransom

(a) RESIDENCE NO. 2397 N Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	colored	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ida Ransom

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	76			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) Janitor
(c) Name of employer Jesse Waldorf

9 BIRTHPLACE (city or town) Essex Co.
(State or country) Va

PARENTS

10 NAME OF FATHER Turner Ransom

11 BIRTHPLACE OF FATHER (city or town) Essex Co
(State or country) Va

12 MAIDEN NAME OF MOTHER Rebecca Russell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Bettie Moulton
(Address) 1436 W Lexington St.

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Myocarditis

Broncho Pneumonia (duration) 2 yrs. mos.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) C. E. Straus, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Jan. 29 1930
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 3221 Schroeder St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 2 31930

C. H. THOMPSON, M.D.S., M. D.

Spec.—1-10-21—M&T—1500 Blks.

E 53478 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53478

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3404 Fairview Ave (St.) 15-61 (Ward)

2-FULL NAME Zeruth A. Saunders

(a) RESIDENCE NO. 3404 Fairview Ave (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced (Husband of) (the) WIFE of William Saunders

6 DATE OF BIRTH (month, day, and year) July 14 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS

10 NAME OF FATHER William Saunder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nova Scotia

12 MAIDEN NAME OF MOTHER Chloe Patten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nova Scotia

14 Informant George E. Saunders

(Address) 230 E Lanvale Ave

15 Filed . 19 C. HAMPSON COMR. H. D. Registrar

N 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I attended deceased from June , 1929, to Jan 27 , 1930, that I last saw h alive on Jan 25 , 1930, and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Acute dilitation of Heart

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. S. Hibbitt, M. D.

1/29/30 (Address) 2220 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Jan 30 1930
20 UNDERTAKER George J. Smith	ADDRESS 1132 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 53479

Dorothy V Haynes

101-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E. 53[illegible]

REGISTERED NO.

1-PLACE OF DEATH Coroner's dead at Franklin Sq. Hospital 19-26

City of Baltimore: (No. St., (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dorothy V. Haynes

(a) RESIDENCE NO. 216 N. Carey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24-1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		1	3 ~~28~~	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Oscar Haynes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto md

12 MAIDEN NAME OF MOTHER Annie Dickerson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Annie Dickerson
(Address) 216 N. Carey St.

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

Jan 27, 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	1/29/30
20 UNDERTAKER	ADDRESS
Samuel L Hemsley	1538 Bdle

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53480

E 53480

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4305 Wentworth Rd St. 28-64 Ward)

2-FULL NAME Jefferson Zachery Taylor

(a) RESIDENCE NO. 4305 Wentworth Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	W.	married

5a If married, widowed, or divorced HUSBAND of ~~or] WIFE of~~ Hannah Erma Evans

6 DATE OF BIRTH (month, day, and year) 8-29-1848

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	81	4	30 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) Quantico

(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Wesley Taylor

11 BIRTHPLACE OF FATHER (city or town) Quantico

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Wesley Waters

13 BIRTHPLACE OF MOTHER (city or town) Kingston

(State or country) Maryland.

14 Informant H. Erma Taylor

(Address) 4305 Wentworth Rd.

15 Filed ..... 19 ..... C. HARRISON JONES M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 1930

17

I HEREBY CERTIFY, That I attended deceased from Nov 15 1929, to January 28, 1930,

that I last saw him alive on 1-24, 1930,

and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

organic heart disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Christel Rukand, M. D.

1-28. 1930 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Lorraine Park Cemt Date of Burial Jan 30 1930

20 UNDERTAKER Botsam & Poe ADDRESS 1723 W Lafayette Ave

tion should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53481 ✓ E 53481

E 53481

CERTIFICATE OF DEATH

24

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. 10-14

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Allen

(a) RESIDENCE NO. 1207 E. Madison St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Allen

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
44 45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Richmond Va
(State or country)

PARENTS

10 NAME OF FATHER Thomas Allen

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va.

14 Informant Bessie Allen
(Address) 1207 E. Madison St

15 Filed JAN 29 1930 16 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-26-30

17 I HEREBY CERTIFY, That I attended deceased from 1/26, 19 30, to 1/26, 19 30, that I last saw h in alive on 1/26/30, 19 ..... and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Meningitis - prob. Meningococcus

(duration) about yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) David Seine, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. National Cem.

DATE OF BURIAL 1-30 1930

20 UNDERTAKER Byron & Wright 1218 McCulloh St

ADDRESS .....

IMPORTANT. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53182 E 53182

REGISTERED NO. 51-69

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2201 Fenwick St.) WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W Draper

(a) RESIDENCE NO. 2201 Fenwick Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 5 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Draper.

6 DATE OF BIRTH (month, day, and year) Aug 1st 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	5	27	

8 OCCUPATION OF DECEASED,

(a) Trade, profession or particular kind of work machinist helper.

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer Balto News.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER, Chester Draper.

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER Mary Hickey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio Ireland.

14 Informant Mrs Mary E Draper.

(Address) 2201 Fenwick Ave

15 Filed JAN 29 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28-30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1930, to Jan 28, 1930, that I last saw him alive on Jan 27, 1930 and that death occurred, on the date stated above, at 3.30 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Date of

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Lab & P. E.

(Signed) Dorsey E. Todd, M. D.

1/28, 1930 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Jan 31st 1930

20 UNDERTAKER John J. Howard & Son

ADDRESS 400 Holliday St.

IMPORTANT. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53483

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53483

CERTIFICATE OF DEATH

31

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 S. Collington Ave ST. 70-70 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Carroll,

(a) RESIDENCE NO. 325 S. Collington Ave ST., _____ WARD _____ (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 11 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Feb. 25. 1907.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Amer. Eff. Co.

(c) Name of employer Amer. Eff. Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James P. Carroll,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary A. Murphy,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs Mary A. Carroll,

(Address) 325 S. Collington Ave

15 Filed ... 19... ... Registrar.

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26. 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 1a, 1929, to Jan 26, 1930, that I last saw h[illegible] alive on Jan 26, 1930, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. 1 ds.

CONTRIBUTORY (Secondary) None (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam etc.

(Signed) Chas. Norton, M. D.

1/26, 1930 (Address) 888 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 1/30 1930.

20 UNDERTAKER John J. Cowan & Son.

ADDRESS 901 Walker St.

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 V

E 53484

REGISTERED NO. E 53484

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) # 16 West Hill ST. 23-31 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Meister

(a) RESIDENCE NO. # 16 West Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo F Meister

6 DATE OF BIRTH (month, day, and year) Aug 18th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Flowers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Geo F. Meister

(Address) # 16 West Hill St.

15 Filed JAN 29 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/29/1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1929 to Jan 29 1930

that I last saw h alive on Jan 25 1930

and that death occurred, on the date stated above, at 12.05 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. K. Campbell M.D.

1/29, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.

DATE OF BURIAL 1/31/1930

20 UNDERTAKER John F. Coward & Son

ADDRESS 1201 Hollins St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓ E 53485

REGISTERED NO. 22-30

E 53485

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ± 9 W. Barre ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maria James

(a) RESIDENCE NO. ± 9 W. Barre ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. + mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry James

6 DATE OF BIRTH (month, day, and year): July 4 1876

7 AGE — Years: 54 | Months: 6 | Days: 23 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home Work 070
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Robt Page.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Mary Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mary Ward
(Address) 9 W. Barre St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan - 27-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Jan 27, 1930,
that I last saw her alive on Jan 27, 1930
and that death occurred, on the date stated above, at 11 20 P. m.
The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
(duration) yrs. mos. 26 da.
CONTRIBUTORY (Secondary) Acute nephritis
(duration) yrs. mos. 8 da.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Dan Truslow M. D.
1/28, 1930 (Address) 1122 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va

DATE OF BURIAL: Jan. 29, 1930

20 UNDERTAKER: Mrs. P. A. Elliott.

ADDRESS: 1725 Ashland Ave.

Important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53486

E 53486

CERTIFICATE OF DEATH

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2239 Madison St., 6-14-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Henson

(a) RESIDENCE NO. 2239 Madison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John Henson

6 DATE OF BIRTH (month, day, and year): Unknown 1850

7 AGE: Years 75 Months 74 Days

IF LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge, (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mary Henson (Address) 2239 Madison Ave

15 Filed JAN 29 1930, 19 C. HAMPSON JONES, Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27 1930

17 I HEREBY CERTIFY That I attended deceased from July 25, 1930, to July 27, 1930, that I last saw h[illegible] alive on July 27, 1930, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

(1) Cerebral Hemorrhage

(duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted Home

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas P. Coleman M. D.

(Address) 1504 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Md. Date of Burial: Jan. 30 1930

20a UNDERTAKER: Mrs. P. G. Elliott

ADDRESS 1726 McCulloh

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53487

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53487

CERTIFICATE OF DEATH

1—PLACE OF DEATH U.S. Marine Hospital
Baltimore, Maryland

REGISTERED NO. 12-51

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joe Lopez

(a) RESIDENCE NO. Lisbon, Portugal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Malang

9 BIRTHPLACE (city or town) (State or country) Lisbon, Portugal

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Maryland

15 Filed NOV 29 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 21, 1930, to January 28, 1930, that I last saw him alive on January 27, 1930, and that death occurred, on the date stated above, at 2:00 A.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobar, right upper

(duration) unknown yrs. mos. da.

CONTRIBUTORY (Secondary) None

(duration) unknown yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Ralph L Porter, M. D.

1/28, 1930 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden

DATE OF BURIAL Jan. 30, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc.

ADDRESS 125 E. North ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 53488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓ E 53488

10-14

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 906 Donnelly's Court St., Ward)

2-FULL NAME Wm. Vaughn

(a) RESIDENCE NO. 906 Donnelly's Ct St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S., if of foreign birth? ... yrs. ... mos. ... da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	B	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Vaughn

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Maria Vaughn

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant John Vaughn
(Address) 906 Donnelly's Ct.

15 Filed ..... 19 .....

JAN 29 1930 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

..... (duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. H. Cullen, M. D.

1/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL ... 19

20 UNDERTAKER C. Hanson Jones Jr. — ADDRESS JAN 29 1930

Commissioner Health

Per C. H. J. Jr.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53489 — 31 — E 53489

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 713 WARD)

2—FULL NAME Dora Stanley

(a) RESIDENCE NO. 1826 E. Madison st. ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
31	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER I. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER E. Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) UNIV

15 Filed JAN 29 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22, 1929, to Jan. 22, 1930, that I last saw her alive on Jan. 22, 1930, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

1-22, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JAN 29 1930

important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53490

CERTIFICATE OF DEATH.

16-30

E 53490

1-PLACE OF DEATH

City of BALTIMORE: (No. 1146 Russel St. 7-31 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Neal

(a) Residence No. 1146 Russel St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1/24/30

7-AGE. ....yrs. ....mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country), Md

PARENTS.

10-NAME OF FATHER, David Banks

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Neal.

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md

11- (Informant).....

(Address).....

15- Dec. 1930. C. HAMPSON JONES, M. D. Registrar.

JAN 29 1930 Reg. 1312

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 1-27-30

17- I HEREBY CERTIFY, That I attended deceased from 1/24/ 1930 to 1/27/ 1930 that I last saw h/[illegible] alive on 1/26/ 1930 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

32 wk. premature infant

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Louis H. Kong Jas. M. D

1/28 1930 (Address) Mercy Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. VERSITY OF MARYLA

DATE OF BURIAL. ....., 19....

20-UNDERTAKER, [illegible]

ADDRESS JAN 29 1930

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53191

CERTIFICATE OF DEATH

3 | E 53191

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 611 W. Mulberry St. 17-25 Ward)

2-FULL NAME Robert Eubanks

(a) RESIDENCE NO. 611 W. Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Eubanks

6 DATE OF BIRTH (month, day, and year) June 27-1910

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	19	7	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Richmond, Va.

PARENTS

10 NAME OF FATHER Walter Eubanks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Maggie Finney

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs. Walter Eubanks
(Address) 611 W. Mulberry St.

15 Filed 1-30 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Talley M. D.

1/27. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn - Cem

DATE OF BURIAL 1-30 1930

20 UNDERTAKER Chas. B. Alexander

ADDRESS 1466 Druid Hill Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53492 90E 53492

CERTIFICATE OF DEATH

REGISTERED NO. 1355

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 N. 37th St. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Schieswohl

(a) RESIDENCE NO. 1113 N. 37th St. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 11 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Schieswohl

6 DATE OF BIRTH (month, day, and year) Feb. 20-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michel Huppman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Rhinefelter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss. Margaret R. Schieswohl

(Address) 1113 N. 37th St.

15 Filed JAN 29 1930

C. HAMILTON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28-1930.

17 I HEREBY CERTIFY That I attended deceased from Dec 15, 1929, to Jan 27, 1930.

that I last saw her alive on Jan 27, 1930

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

19 (Address) 9632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Jan. 31-1930.

20 UNDERTAKER Horace F. Bugee ADDRESS 3631 Falls Road

Form ... important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53193 | CERTIFICATE OF DEATH | 129 E 53193

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Covington St. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles E. Mortimer

(a) RESIDENCE NO. 1424 Covington St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 11 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen L. Mortimer

6 DATE OF BIRTH (month, day, and year) Feb 5 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer) $6

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Emma Smith

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. Lipp

(Address) 1424 Covington St

15 Filed JAN 29 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27. 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 25 1929 to Jan 27 1930

that I last saw him alive on Jan 26. 1930

and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows: Uremia & Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Boettner M. D.

1/28. 1930 (Address) 1 E Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 1/30 1930

20 UNDERTAKER I. Few McCully

ADDRESS 130 E Fort

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53194

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53194

CERTIFICATE OF DEATH

31

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 North Curley st. ST., 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Picek.

(a) RESIDENCE NO. 622 N. Curley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 10 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Factory.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER James Picek

11 BIRTHPLACE OF FATHER (city or town) Hlocov
(State or country) Czechoslovakia.

12 MAIDEN NAME OF MOTHER Anna Lasnovsky

13 BIRTHPLACE OF MOTHER (city or town) Veletov
(State or country) Czechoslovakia.

14 Informant James Picek
(Address) 2420 Ashland Ave

15 FEB 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29. 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Jan 29, 1930
that I last saw her alive on Jan 29, 1930
and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos. da.

CONTRIBUTORY (Secondary) Cardiac Dyspepsia

(duration) yrs. 1 mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Ray Davis, M. D.

1-29-30 (Address) 801 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dolphin Hill Cemetery	Jan. 31 1930
20 UNDERTAKER	ADDRESS
August Pasek	2406 Ashland Ave

important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53495 90 E 53495

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 610

CITY OF BALTIMORE: (No. 2738 E. Baltimore ST. 610 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christie Ella Neuschafer

(a) RESIDENCE NO. 2738 E. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 - 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	54		4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tipper
(b) General nature of industry, business, or establishment in which employed (or employer) Umbrellas
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS
10 NAME OF FATHER Wm C. Neuschafer
11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Dora Boos
(Address) 2738 E. Baltimore St

15 Filed ..., 19 C. HAMPSON JONES, M. Registrar
N 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930 to Jan 28, 1930, that I last saw her alive on Jan 28, 1930 and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows: Chronic Cardiac Dilitation

(duration) Not definite da.

CONTRIBUTORY (Secondary)
(duration) ...yrs...mos...da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden, M. D.

1/28/, 1930 (Address) 1216 N. Carlton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Jan 30 1930
20 UNDERTAKER	ADDRESS
Chas E. Miller & Son	2534 Jefferson

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

(Creagh)

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-009 V

E 53496

CERTIFICATE OF DEATH

E 53496

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME, instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital St., 13-20 Ward)

2-FULL NAME Milton Creagh

(a) RESIDENCE NO. 612 W. North ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 16 1915

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	14	6	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) In Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Creagh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Margaret Creagh
(Address) 612 W North Ave

15 Filed ..., 19.... ..... Registrar

JAN 29 1930 C. HERBERT JONES, M. D. Dep. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident. He sled struck a tree, injured internally

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Ruptured Spleen, Hemorrhage

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke M. D.

Jan 27, 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Jan 30, 30
20 UNDERTAKER	ADDRESS
Jos. E. Miller & Son 2537	Jefferson St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53497

CERTIFICATE OF DEATH

91-007 ✓ E 53107

1—PLACE OF DEATH Balto City Hosp. REGISTERED NO. 9-12

CITY OF BALTIMORE: (No. Balto Md ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Melgard

(a) RESIDENCE NO. 2405 E. Monument St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margery Melgard

6 DATE OF BIRTH (month, day, and year) April 7, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) None 0+5

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Alexander Melgard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Henrietta Melgard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Friends (Address) Balto City Hosp.

15 Filed JAN 29 1930 C. MANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-25-30

17 I HEREBY CERTIFY, That I attended deceased from 11-27-, 19 29, to 1-25-, 19 30,

that I last saw h alive on 1-27-, 19 30

and that death occurred, on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY Psychosis c Hypertension + (Secondary) Cerebral Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) Harry Fedman M. D.

1-25, 19 30 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Jan. 31 1930
20 UNDERTAKER C. Miller & Son	ADDRESS 2331 Gilmor St.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53498

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53498

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 Lancaster St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Seidler

(a) RESIDENCE NO 1802 Lancaster St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	CR	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Seidler

6 DATE OF BIRTH (month, day, and year) Dec 7 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65		22	
	66	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph Seidler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary Seidler

(Address) 1802 Lancaster St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

BY AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Jan 29, 1930, that I last saw h[illegible] alive on Jan 29, 1930 and that death occurred, on the date stated above, at 9 1/4 a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 2 yrs. 2 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Louis Rosenstein M. D.

1/29, 1930 (Address) 1800 E Monument St

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft. Stanleons	Feb 1 1930
20 UNDERTAKER M. W. E. Dupper	ADDRESS 37 Lamb

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53199 (duplicate) E 53199 — 101-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2694 Dulaney ST. 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna M. Mooney

(a) RESIDENCE NO. 2694 Dulaney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 7 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed or divorced — HUSBAND of (or) WIFE of: Edwin P. Mooney

6 DATE OF BIRTH (month, day, and year): November 11th 1898

7 AGE: Years 31 | Months 2 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (City or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Lehner

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mathilda Yeager

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Edwin P. Mooney

(Address) 2694 Dulaney St.

15 Filed JAN 29 1930 C. HAWSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 28th 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 17 1930 to Jan 28 1930

that I last saw h-- alive on Jan 28 1930

and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Pyelonephritis (duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Nath'l E. Steele M. D.

1/29 1930 (Address) 215 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Jan 31st 1930

UNDERTAKER: F. B. Wenfert — ADDRESS: 1550 N. Eutaw St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Va Ketzelinger
E 53502 Emma Sullivan

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 53500

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE, (No.) 100 S. Mount ST., 14-28 WARD)

2—FULL NAME Emma F. Dunsmore

(a) RESIDENCE NO. 100 S. Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 2 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

.a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Dunsmore

6 DATE OF BIRTH (month, day, and year) Nov 26th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John J. O'Hara

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary E. Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant Geo H. O'Hara
(Address) 100 S. Mount St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27th 30

17 I HEREBY CERTIFY, That I attended deceased from Dec 10 1929 to Jan 27 1930.

that I last saw h alive on Jan 26 1930

and that death occurred, on the date stated above, at 5-15 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. 17 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Nov 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical + Clinical

(Signed) Jas A Dickey M.D.

1/29/30 (Address) 1729 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Jan 30 1930

UNDERTAKER J. B. Wyman

ADDRESS 1850 N. Gilmor St

Important. See instructions on back of certificates.

JAMES H. JONES, M.D.
JAN 29 1930

Spec.—1 12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53501

53501

CERTIFICATE OF DEATH.

49

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1309 N. Central av ST. (WARD) 4-18

2-FULL NAME Joseph. Libertini

(a) RESIDENCE NO. 1309 N. Central av ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pl. Delicia Libertini

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) F. X. Gaustin

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Louis Libertini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Rosa. Casa.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Delicia Libertini

(Address) 1309 Central av

Filed JAN 30 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28-1930

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to Jan 27, 1930, that I last saw h alive on Jan 27, 1930 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Womathein, M. D.

1/29, 1930 (Address) 733 Argyle ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemy

DATE OF BURIAL Jan 30 1930

20 UNDERTAKER J. Rush

ADDRESS 1735 Harford av

Spec.—2-29-28—L. F. S.—500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53502

E 53502

CERTIFICATE OF DEATH

REGISTERED NO. 101-00

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 147 W. Hamburg ST.) 23-3 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjamain G. Boyer

(a) RESIDENCE NO. 147 W. Hamburg ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie L. Boyer

6 DATE OF BIRTH (month, day, and year) Feb 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Benjamin Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Maggie L. Boyer

(Address) 147 W. Hamburg St.

15 [illegible] M.D.

16 [illegible] Registrar

JAN 30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1930 to Jan 27 1930 that I last saw him alive on Jan 27 1930 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) No Known

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) Charles O'Flowers, M. D.

Jan 27 1930 (Address) 7th & Main

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Jan 30, 1930

20 UNDERTAKER John N. Tradewin — ADDRESS 1027 Edmondson Ave

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 53503

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Argyle Ave ST. (or AVE.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leo H. Dannon

(a) RESIDENCE NO. 1407 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Mar.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mamie

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 52 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bookbinder

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Balto

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Dannon

(Address) 1407 Argyle Ave

15 Filed 19 Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Jan 28/30

17

I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930 to Jan 28, 1930, that I last saw h alive on Jan 27, 1930 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? J H

(Signed) J. H. Norwood, M. D.

Jan 31/30, 19 (Address) 937 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 2/3 1930

20 UNDERTAKER: Geo. L. Holland — ADDRESS: 1631 Druid Hill Ave

I. Be sure every item is correct. 2. Write plainly, with unfading ink.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53504

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001.

CERTIFICATE OF DEATH

E 53504

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 13-32 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William M. White

(a) RESIDENCE NO. 1719 S. Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary White

6 DATE OF BIRTH (month, day, and year) Dec. 4 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	2 1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lineman

(b) General nature of industry, business, or establishment in which employed (or employer) Power Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

JAN 30 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-28-30

17 I HEREBY CERTIFY, That I attended deceased from 1-17, 1930, to 1-28, 1930, that I last saw h[illegible] alive on 1-28, 1930, and that death occurred, on the date stated above, at 10 1/2 p m.

The CAUSE OF DEATH* was as follows:

Acute lung abscess right side

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 1-24-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. U. Lumpkin, M. D.

1-29, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Feb. 2 1930

20 UNDERTAKER Chas. L. Sievers — ADDRESS 1508 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53505 — E 53505

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph Hospital — REGISTERED NO. .....

CITY OF BALTIMORE; (No. 6 Eutaw & Oliver Sts.) (ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Gossman

(a) RESIDENCE NO. 942 Augusta ST., 27 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Not Known yrs. mos. ds. How long in U. S., if of foreign birth? Not Known yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Magdelin Gossman

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years: about 69 | Months: — | Days: — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O&D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs Mintz 935 Stirling St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-24-30 19 .. to 1-29-30 19 .., that I last saw h[illegible] alive on 1-29-30 19 .., and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Arteriosclerosis
(duration) ... yrs. mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ... yrs. ... mos.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis Clinically

(Signed) [illegible] M. D.

1/29 1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Jan. 31 1930

20 UNDERTAKER: Henry Abed & Sons Inc — ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53506

CERTIFICATE OF DEATH

31 E 53506

8-45

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1685 Cliftview ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabelle Constance Schneider

(a) RESIDENCE NO. 1685 Cliftview ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23. 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	21	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Portland
(State or country) Maine.

PARENTS

10 NAME OF FATHER Joseph A. Schneider

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Margaret K. Steinein

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Jos. R. Schneider.
(Address) 2503 Gittings St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 19 30, to Jan. 29, 19 30.
that I last saw h[illegible] alive on Jan 29, 19 30
and that death occurred, on the date stated above, at 12 50 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia. Tuberculosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. J. Stevens, M. D.

1-29 19 30 (Address) 2878 Harford.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feby 1 1930
20 UNDERTAKER	ADDRESS
Henry Hoen Sons, Inc.	130 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 31 1930 [illegible]

Spec.—8-16-29—L. F. S.—100 Bks.

E 53507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO. E 53507

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 N. Washington St. WARD 8-17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Schultze

(a) RESIDENCE NO. 2040 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if foreign birth? 58 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Adolph Schultze

6 DATE OF BIRTH (month, day, and year) Jan. 2 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	84	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Frederick Meier

(Address) 2010 N. Washington St

Filed JAN 30 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 10, 1929, to Jany 29, 1930, that I last saw h alive on 19

and that death occurred, on the date stated above, at 10 25 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed) Hugh Forsythe, M. D.

1, 30, 1930. (Address) 421 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feby 1 1930
20 UNDERTAKER Henry Hoeck Sons, Inc.	ADDRESS 421 E Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53508

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53508

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1236 Mc Elderry ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alvis Wilson

(a) RESIDENCE NO. 847 Northside Sparrows Pt. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O.W.O

(b) General nature of industry, business, or establishment in which employed (or employer) Beth. Steel Co

(c) Name of employer

9 BIRTHPLACE (city or town) Honeyhill (State or country) S. C

PARENTS

10 NAME OF FATHER Abraham Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C

12 MAIDEN NAME OF MOTHER Elizabeth Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C

14 Informant Aaron Green

(Address) 1236 Mc Elderry St

15 Filed JAN 30 1930 C. H. THOMPSON JONES Registrar

16

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30-30

17

I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930, to Jan 30, 1930, that I last saw h alive on Jan 30, 1930 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No Physician

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Jan 30, 1930 (Address) 508 Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamestown S. C

DATE OF BURIAL 1-30 1930

20 UNDERTAKER Byrow Wright

ADDRESS 1218 Mc Elderry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53509 90 E 53509

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2058 Kennedy Av ST., 9-18 WARD)

2—FULL NAME Carrie Virginia Bassett

(a) RESIDENCE NO. 2058 Kennedy Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 1 mos. 5 ds. How long in U. S., if foreign birth 74 yrs. 1 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec 24 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of indastry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer: S. A. von Riesen

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town): unknown (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): unknown (State or country): unknown

14 Informant: Mrs. S. A. von Riesen Employer

(Address): Homewood apts City

15 Filed ....., 19.... Registrar

JAN 30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): January 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930, to Jan 29, 1930, that I last saw h.. alive on Jan. 28, 1930 and that death occurred, on the date stated above, at 7 AM. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 10 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) 10 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John D. Peck, M. D.

Jan 29, 1930 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Cemetery	Jan 30 1930
20 UNDERTAKER: Steward Mower Co	ADDRESS: Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53510 — 73 ✓ — E 53510

CERTIFICATE OF DEATH

REGISTERED NO. 15-67

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3204 Fresbury ST. WARD

2—FULL NAME Alina Julia Plassaig

(a) RESIDENCE NO. 3204 Fresbury ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 22 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alois Plassaig

6 DATE OF BIRTH (month, day, and year): Feby 6 1870

7 AGE — Years: 59 | Months: 11 | Days: 23 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Courtelary Switzerland

PARENTS

10 NAME OF FATHER: W. Guedel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Courtelary Switzerland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Switzerland

14 Informant: Alois Plassaig (husband)
(Address): 3204 Fresbury St.

15 Filed JAN 30 1930 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23d, 1930, to Jan. 29, 1930, that I last saw h er alive on Jan 28, 1930 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus producing Bulbar Paralysis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary): Toxic Thyroid with Auricular Fibrillation

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam + Laboratory

(Signed) A. T. Reis, M. D.

Jan. 30, 1930 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE ~~OF BURIAL~~ CREMATION OR REMOVAL: Fort Lincoln Cemetery Md. | DATE OF BURIAL: Jan 31 1930

20 UNDERTAKER: Stewart & Moore Co. | ADDRESS: Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE BLANKS MUST BE FILLED OUT EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Ruzicka 600 Patterson Park Ave

E 53511

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 53511

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 618 Collington Ave ST., 1-10 WARD)

2—FULL NAME Gerald G. Schulmeyer

(a) RESIDENCE NO. 618 Collington Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6th 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1	-	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Theodore Schulmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Eva Jungelmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Theodore Schulmeyer

(Address) 618 Collington Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28th 1930

17 I HEREBY CERTIFY That I attended deceased from Jan 20 1930, to Jan 28 1930,

that I last saw h[illegible] alive on Jan 28 1930

and that death occurred, on the date stated above, at 6 0 m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M.D.

1930 Address [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 1/31/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks. ... IMPORTANT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Dr Herzog 1308 Park Ave

E 53512 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 E 53512

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 3317 Chelsey Ave ST. Hamilton 27-42 WARD

2-FULL NAME Mary E. Simms

(a) RESIDENCE NO. 3317 Chelsey Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph L. Simms

6 DATE OF BIRTH (month, day, and year): Jan 1, 1855

7 AGE: Years 75 Months 8 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Viola Bryan

(Address) 1308 E. Lanvale St

15 JAN 30 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Jan 29, 1930,

that I last saw her alive on Jan 28, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. F. Herzog M.D. M. D.

1/29, 1930 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 2/1 1930

20 UNDERTAKER: Wm Lorh

ADDRESS: 1217 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Dr McCoy 37 W Preston

E 53513 HEALTH DEPARTMENT—CITY OF BALTIMORE

92

CERTIFICATE OF DEATH.

E 53513

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 West Mt Vernon Pl. ST. 11-25 (WARD)

2-FULL NAME Bert J Fuller Place

(a) RESIDENCE NO. 1 West Mt Vernon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Fuller

6 DATE OF BIRTH (month, day, and year) Nov 4 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs M Jencks

9 BIRTHPLACE (city or town) (State or country) N. J.

PARENTS

10 NAME OF FATHER Gilbert Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Shaddock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Bengal Fuller (Address) 1730 St Paul St

15 Filed JAN 30 1930 19 Registrar

C. HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr, 1925, to Jan 29, 1930.

that I last saw him alive on Jan 26, 1930,

and that death occurred, on the date stated above, at 1.0 m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis -

2 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Vascular spasm.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry H. McCarty M. D.

1-30-1930 (Address) 37 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Keene, N H — DATE OF BURIAL 1/31 1930

20 UNDERTAKER W. M. Cook — ADDRESS 1217 St Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AN 30 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 53514

E 53514

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 N. Bond St. ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Foley.

(a) RESIDENCE NO. 1401 N. Bond St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thomas J. Brooks

(Address) 1401 N. Bond St.

15 Filed 19 Registrar

JAN 30 1930 C. FRED ROBERTS, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29th, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to Jan 29, 1930, that I last saw her alive on Jan 28, 1930 and that death occurred, on the date stated above, at 1-30 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(doration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cor pulmo. mitral

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. G. Prentiss, M. D.

, 19 (Address) 634 Gaswell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Feb. 1st. 19 30.

20 UNDERTAKER Chas E. Ware & Son 118

ADDRESS W. Mt Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

CROUSE

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 53515

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 309 W. Hoffman St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Crouse

(a) RESIDENCE NO. 309 W. Hoffman St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Doris Crouse

6 DATE OF BIRTH (month, day, and year) April 25th, 1878.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Joseph Crouse

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Ziegler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant (Address) Mary Doris Crouse 309 W. Hoffman St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 28, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930 to Jan 28, 1930.

that I last saw him alive on Jan 28, 1930.

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cerebral Hyperemia

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schwenck M. D.

19 (Address) 1337 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

Date of Burial 1/31 1930

20 UNDERTAKER Chas. P. Maus & Son ADDRESS 1118 N. Howard St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53516

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53516

CERTIFICATE OF DEATH

45

REGISTERED NO. 9-18

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 E Lanvale ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Barbara A. Hitz

(a) RESIDENCE NO. 1104 E. Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Married

5a If married, widowed, or divorced (or) WIFE of Benj. Hitz

6 DATE OF BIRTH (month, day, and year) May 5th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France Ger.

PARENTS

10 NAME OF FATHER Geo. A. Hofmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Sophie M. Hammer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Benj. Hitz

(Address) 1104 E. Lanvale

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jany 29/30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1929 to Jany 29, 1930, that I last saw her alive on Jany 28, 1930 and that death occurred, on the date stated above, at 7.55 A.M.

The CAUSE OF DEATH* was as follows:

Cancer (Carcinoma) of sigmoid colon

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Anaemia & Gen. Weakness (duration) 1 yrs. One mos. ds.

18 Where was disease rontracted if not at place of death?

Did an operation precede death? No Data of

Was there an autopsy? No

What test confirmed diagnosis? Palpable

(Signed) E. Smith, M. D.

1/29, 1930 (Address) 1605 N. Norwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL Feb 1 1930

20 UNDERTAKER Josiah Pfeffer

ADDRESS 1600 N Howard

mation should be carefully supplied. Age should be stated EXACTLY. Physician's Certificate OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 31

E 53517

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. + 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Edw. Ayres

(a) RESIDENCE NO. Essex Farm Guilford ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula J. Ayres

6 DATE OF BIRTH (month, day, and year) Nov 22-1883

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Mr. John M. Lewis

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co. (State or country) Md

PARENTS

10 NAME OF FATHER James Ayres

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co.

12 MAIDEN NAME OF MOTHER Sarah Harmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co

14 Informant Lula J. Ayres

(Address) Guilford

15 Filed JAN 30 1930 19 C. H. [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30-30

17 I HEREBY CERTIFY, That I attended deceased from 1-22, 1930, to 1-30, 1930, that I last saw him alive on 1-29, 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of L. lung

had been ill since 20 yrs old.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis meningitis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Leroy L. Leet, M. D.

1-30, 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Waters Memorial Church, Harford Co.	Feb. 2, 1930.
20 UNDERTAKER Helm Burns Sons	ADDRESS Towson

Information should be carefully supplied. All items should be stated EXACTLY. Abbreviations should not be used. Write plainly in ink. Be sure that the statement of OCCUPATION is very important. See instructions on back of certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53518 — 74-002 — 53518

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2817 Rayner Ave (St.) 46-66 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella A Cushwa

(a) RESIDENCE. No. 2817 Rayner Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David F Cushwa

6 DATE OF BIRTH (month) June 1st 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Francis Kerns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Ann Devine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmington Delaware

14 Informant David F Cushwa
(Address) 2817 Rayner Ave

15 Filed Jan 30 1930 C. HOWARD JONES, M.D. Registrar

JAN 30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) January 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 18th 1930 to Jan 28th 1930 that I last saw her alive on Jan 28th 1930 and that death occurred, on the date stated above, at 7.05 P m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Exam

(Signed) George Jungmann III M. D.

1/29 1930 (Address) 46 E 25th St.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Jan 31 1930

20 UNDERTAKER — ADDRESS

Mary A Gaughan 25 St Rayner Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 53519

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Whitelock ST. 13-59 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edmonia Harris

(a) RESIDENCE NO. 1502 Whitelock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	Married

6a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Moses Harris

6 DATE OF BIRTH (month, day, and year) Oct 16-1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maria Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Moses Harris

(Address) 1502 Whitelock St

15 Filed JAN 30 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8. 1929 to Jan 29 1930

that I last saw h alive on Jan 28 1930

and that death occurred, on the date stated above, at 7-50 A m.

The CAUSE OF DEATH* was as follows:

Acute Uraemia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chr Pancreatitis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Paul Brown, M. D.

1/28. 1930 (Address) 1662 W Mount Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Adams Middlesex Co Va

DATE OF BURIAL Feb 2 1930

20 UNDERTAKER Jno. W. Chase & Son

ADDRESS 1405 Mosher

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53520

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53520

CERTIFICATE OF DEATH

REGISTERED NO. 172-002

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1825 Bolton ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles H. Frederick

(a) RESIDENCE NO. 1825 Bolton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Elizabeth Frederick

6 DATE OF BIRTH (month, day, and year) July 19 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Runner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER H. C. Frederick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Elizabeth Frederick
(Address) 1825 Bolton St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to Jan 29, 1930,
that I last saw h alive on Jan 29, 1930
and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Albert Singer M. D.

1/30, 1930 (Address) 1603 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 1 1930
20 UNDERTAKER	ADDRESS
Geo. J. Henkins & Co	Orland & Mc Culloh

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

53521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

53521 ✓ E 53521

129

1—PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Women Hospital 14-20 WARD)

2—FULL NAME Alice Peace

(a) RESIDENCE NO. Union Home Women Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 63 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 15. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse - Supt Home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Murdock Peace

11 BIRTHPLACE OF FATHER (city or town) Scotland (State or country)

12 MAIDEN NAME OF MOTHER Margaret Toy

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant M. Frances Peace

(Address) 408 Park Ave

15 JAN 30 1930 HAMSON JOHNS M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930, to Jan 29, 1930, that I last saw h[illegible] alive on Jan 29, 1930 and that death occurred, on the date stated above, at 3 20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. 6 days

CONTRIBUTORY (Secondary) Chronic arthritis

Myocarditis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? ...

(Signed) Olesse G. Hardyce, M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	1-31 1930
20 UNDERTAKER	ADDRESS
Henry W. Jenkins & Bro Co	Orchard & McCulloh Sts

mation should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53522

CERTIFICATE OF DEATH.

91

E 53522

1-PLACE OF DEATH

City of BALTIMORE: (No. 2817 N. Calvert St. 12-50 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice A Holt

(a) Residence No. 2817 N. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Sept 25-1871

7-AGE. 48 4 4

48 yrs. 8 mos. 7 ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer). Own shop

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Holt first name unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary McKenna

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Mary Bowles

(Address) 2817 N. Calvert St.

15- [illegible] C. HAMPSON JONES, M. D. Registrar.

JAN 30 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Jan 29th 30

17- I HEREBY CERTIFY, That I attended deceased from Nov. 26th 1929 to Jan 29th 1930

that I last saw her alive on Jan 29th 1930

and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

Unknown (Duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

— (Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frederick D. Grey M. D.

, 19 (Address) 2827 Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	Jan 31 1930
20-UNDERTAKER.	ADDRESS
James B Ayres	1324 Eutaw Place

WHITE—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53523 31 E 53523

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3458 Keswick Rd 43-5 ... WARD)

2-FULL NAME Stanley Vaughan Merson

(a) RESIDENCE NO. 3458 Keswick ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. . mos. ds. How long in U. S., if of foreign birth? yrs. . mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joshua Anna Merson

6 DATE OF BIRTH (month, day, and year) Oct 14 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	27	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caroline Cafeteria Attendant

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Bartholow's

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Merson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Laural Md

12 MAIDEN NAME OF MOTHER Emma Edgar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredericksburg Va

14 Informant Stanley Merson
(Address) 3458 Keswick Rd

15 JAN 30 1930 C. HAMPSON JONES, M. D. Registrar
By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/28 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1924, to Jany 28, 1930, that I last saw him alive on Jan 28, 1930, and that death occurred, on the date stated above, at 11 40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) 5 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonal Atelectasis

(duration) ... yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Lucas Feldman, M. D.

, 19 (Address) 1656 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Jan 31 1930

20 UNDERTAKER Thanhouser Stone — ADDRESS 3616 Clinton

B.—WRITE PLAINLY, WITH UNFADING INK. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53524 E 53524

CERTIFICATE OF DEATH

90

21-31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 714 Berry St. ST. (AND)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Belt.

(a) RESIDENCE NO. 714 Berry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Belt

6 DATE OF BIRTH (month, day, and year) Aug 8, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mary C. Belt.
(Address) 714 Berry St.

15 Filed JAN 30 1930 C. H. EMERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 28, 1930, that I last saw him alive on Jan 28, 1930, and that death occurred, on the date stated above, at 4.50 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. H. Emerson Jones, M. D.

1/29, 1930 (Address) 17 W. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Hampden.

DATE OF BURIAL Feb 1, 1930

20 UNDERTAKER Edmondson

ADDRESS 3615 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is very OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53525

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53525

CERTIFICATE OF DEATH

144

REGISTERED NO. 1

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther Shifflett

(a) RESIDENCE NO. 1510 W. 36 ST., WARD 5th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert

6 DATE OF BIRTH (month, day, and year) Sept-16-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thomas Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Florence Shifflett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 JAN 30 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-27-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1930, to Jan 27, 1930, that I last saw her alive on Jan 27, 1930 and that death occurred, on the date stated above, at 8 20 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Post partum hemorrhage

(duration) yrs. 10 mos. da.

CONTRIBUTORY (Secondary) Postpartum hemorrhage (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? None Date of

Was there an autopsy? None

What test confirmed diagnosis? X-Ray

(Signed) Herbert F. Traut, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Va.

DATE OF BURIAL Jan 31 1930

20 UNDERTAKER Chenoweth & Son

ADDRESS 3615 Chestnut Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 53526

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Leitth Sisters of the Poo ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Hannagan

(a) RESIDENCE NO. Preston + Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11 Oct 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	77	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thomas Hannagan

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Ann Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Leitth Sisters of the Poor
(Address) Preston + Valley Sts

15 Filed ____, 19__ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1930, to Jan 29 1930, that I last saw h[illegible] alive on Jan 28 1930 and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Unknown (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease (duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Dr Elmer Lowe, M. D.

1/29 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
NEW CATHEDRAL CEM	FEB 1 1930
20 UNDERTAKER	ADDRESS
ROBERT BROOKS & SON	CALHOUN HOLLINS 38

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53527

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53527

1—PLACE OF DEATH University Hospital REGISTERED NO. 46

CITY OF BALTIMORE: (No. ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Bessie Thomas

(a) RESIDENCE NO. 7 Erndale ST., Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Thomas Jr

6 DATE OF BIRTH (month, day, and year) Oct 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	49	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Hagerstown (State or country) Md

PARENTS

10 NAME OF FATHER Chas. F. Fridinger

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Anna Riecodemus

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Wm H Thomas Jr

(Address) Erndale Md

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

JAN 30 1930 Pat ack

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30-30

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Jan 30, 1930.

That I last saw her alive on 1-30-30 19...

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) yrs. 4 mos. da.

CONTRIBUTORY (Secondary) Uraemia Acute

Leake yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. V. Leake, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown, Md

DATE OF BURIAL: 2/1 1930

20 UNDERTAKER Wm E Cook

ADDRESS 1217 E Pratt St

Information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 53528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1514 Paca ST. 11-20 (WARD)

2-FULL NAME Mrs. Elizabeth Lessner

(a) RESIDENCE NO. 1514 Paca ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lessner

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown - Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mrs. Clara Lessner
(Address) 1514 Paca St.

15 Filed JAN 30 1930, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930 to Jan. 30, 1930.

that I last saw her alive on Jan. 30, 1930.

and that death occurred, on the date stated above, at 5 20 A.m.

The CAUSE OF DEATH* was as follows:

Chronic myo - + endo - carditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Dr. A. B. Seybert, M. D.

, 19 (Address) 2802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 2/1 1930

20 UNDERTAKER H. J. Cook

ADDRESS 1217 E. Lanvale St.

C. HAMILTON JONES, M. D.
CITY HEALTH COMMISSIONER

Spec.—1-30—M. & T.—250 Blks.

D. Calvert House 1901 Eutaw Place
mad 5627

E 53529 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53529

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3117 Milford Ave (St.) Howard (Hospital) 2 8 1 4

2-FULL NAME George Leonard Kline

(a) RESIDENCE No. 3117 Milford Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Lula C

6 DATE OF BIRTH (month, day, and year) Nov 30th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	2	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Machine Shop
(c) Name of employer Bowers Cork & Seal Co

9 BIRTHPLACE (city or town) Penna
(State or country)

PARENTS

10 NAME OF FATHER Lyman Kline

11 BIRTHPLACE OF FATHER (city or town) Penna
(State or country)

12 MAIDEN NAME OF MOTHER Amanda S Arment

13 BIRTHPLACE OF MOTHER (city or town) Penna
(State or country)

14 Informant Mrs Lula C Kline
(Address) 3117 Milford ave

15 Filed JAN 30 1930 19 C. H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30/1930

17 I HEREBY CERTIFY, That I attended deceased from November 1st 1929, to January 30th 1930, that I last saw him alive on Janaury 29th 1929, and that death occurred, on the date stated above, at six A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis and Chronic Nephritis

2
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

2
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? --

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) C. H. Wilson Jones M. D.

1/30/30 (Address) 1901 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Altoona Penna — DATE OF BURIAL 1/31/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53530

88 E 53530

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals St. 22-30 Ward)

2-FULL NAME Mary A Bouce

(a) RESIDENCE NO. 536 Hanover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, ~~Married~~, Widowed ~~or Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Untermound

6 DATE OF BIRTH (month, day, and year) July 22 1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
55	56	6	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housework 039
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John McNeil

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Tued

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Bulk city Hospital
(Address)

15 Filed ..... 19 ..... Registrar

JAN 31 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

DC Myocarditis

(duration) 1 yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Jan 30 3

What test confirmed diagnosis? Phy Exam

(Signed) G O Glades, M. D.

. 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Patrick Cemetery

DATE OF BURIAL Feb 1 19 30

20 UNDERTAKER Fred A Williamson

ADDRESS 703 Hanover

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53531

90 E 53531

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara Kochanski

(a) RESIDENCE NO. 709 S. Robinson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65 ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Poland

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed JAN 31 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29-30

17 I HEREBY CERTIFY, That I attended deceased from 1-25, 1930, to 1-29, 1930, that I last saw her alive on 1-29, 1930 and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 da. ?

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) yrs. over mos. 4 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Martin W. McLean, M. D.

1-29, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Feb 1 1930
20 UNDERTAKER L. W. Bozenski, 1930 Eastern Ave	ADDRESS

REMARKS: Should be carefully supplied. Note should be made EXACTLY. PHYSICIANS should write OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53532 100-001 E 53532

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2431 Alsop ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dolores Mildred Norberg

(a) RESIDENCE NO. 2431 Alsop ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmal

4 COLOR OR RACE: Wh

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 16-1927

7 AGE: Years 2 | Months 5 | Days 13 | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Elmer J. Norberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Gladys Tolliard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Elmer J Norberg

(Address): 2431 Alsop

15 Filed JAN 31 1930, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 19 30, to Jan 29, 19 30

that I last saw her alive on Jan 29, 19 30

and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) Edward J Coon, M. D.

1/29, 19 30 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cmty — DATE OF BURIAL: Feb 1 1930

20 UNDERTAKER: John F Denny — ADDRESS: 715 E. 4 St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53533 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53533

10-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 14-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph B. Airey

(a) RESIDENCE NO. 411 E Hamburg St ST., WARD

(Usual place of abode) Left

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 1, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ella O. Airey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Breeden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Ella O Airey

(Address) 411 E Hamburg

15 Filed JAN 31 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930, to Jan 30, 1930, that I last saw him alive on Jan 30, 1930 and that death occurred, on the date stated above, at 3:00 a. m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Tracheotomy Date Jan 29, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

1/30, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Feb 1 1930
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53534

101-001

E 53534

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 19-27 Ward)

2-FULL NAME William Jones

(a) RESIDENCE NO. 1602 Forney Alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25th 1889

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	40	1	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O+O
(c) Name of employer

9 BIRTHPLACE (city or town) North Cumberland
(State or country) County Va

PARENTS

10 NAME OF FATHER Chas Horsey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Kate Horsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Kate Jones
(Address) 1602 Forney alley

Filed ..... 19 C. P. A. [illegible] Registrar

JAN 31 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

1/28. 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U. S. National Cem — DATE OF BURIAL: Jan 31 1930

20 UNDERTAKER: A. Jones — ADDRESS: 11 S Gilmor

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53535

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 √E 53535

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3332 Elmsley ave ST., 8-40 (WARD)

2—FULL NAME Samuel H. Dennison

(a) RESIDENCE NO. 3332 Elmsley ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lead Worker.

(b) General nature of industry, business, or establishment in which employed (or employer) $6

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown.

14 Informant Mrs. James Meka
(Address) 3332 Elmsley Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30/30

17 I HEREBY CERTIFY That I attended deceased from May, 1929, to Jan 29th, 1930, that I last saw him alive on Jan 29/30 and that death occurred, on the date stated above, at 6 a-m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

uncertain (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) T. J. Tankin, M. D.

, 19 (Address) 119 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 2/1 1930

20 UNDERTAKER Robert Brooks & Son

ADDRESS Catharine & Bouldin

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53536 138 E 53536

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 2900 15-64 WARD)

2-FULL NAME Mrs Josephine Taft De Ford

(a) RESIDENCE NO. The Garrisonian Apts ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. DeFord

6 DATE OF BIRTH (month, day, and year) June 7-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	43	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Worcester Mass.
(State or country)

PARENTS

10 NAME OF FATHER Chas G Taft

11 BIRTHPLACE OF FATHER (city or town) Townsend
(State or country) Vt.

12 MAIDEN NAME OF MOTHER Abigail Burnap

13 BIRTHPLACE OF MOTHER (city or town) Vermont.
(State or country)

14 Informant Charles De Ford
(Address) The Garrison Apts

Filed JAN 31 1930 .19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-22- .1930. to 1-29 .1930.

that I last saw h alive on 1-29 .1930,

and that death occurred, on the date stated above, at 5.25 a. m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pelvic abscess

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 1-26-30

Was there an autopsy? Yes

What test confirmed diagnosis? Drainage

(Signed) George Brown, M. D.

Jan 29 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jan 31 1930

UNDERTAKER Wm J Tickner & Sons — ADDRESS N. Y. Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53537

101-001 E 53537

REGISTERED NO. 15-65

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4105 Alto Road ST., WARD) Round

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriet Maria

(a) RESIDENCE NO. 4105 Alto Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed or divorced HUSBAND of (or) WIFE of: Rev. J. Emory Round

6 DATE OF BIRTH (month, day, and year): Aug 18. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Boston

(State or country): Mass.

PARENTS

10 NAME OF FATHER: Perdan Wesley Case

11 BIRTHPLACE OF FATHER (city or town): New Bedford

(State or country): Mass

12 MAIDEN NAME OF MOTHER: Katherine Hayes

13 BIRTHPLACE OF MOTHER (city or town): Boston

(State or country): Mass

14 Informant: Mrs Jennie Buser

(Address) 4105 Alto Road

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan-16- 1930 to Jan 29- 1930

that I last saw h[illegible] alive on Jan-29 1930

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH was as follows:

Labor Pneumonia Lobus

Sup in Jan-25-1930.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Age 87

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Wesley Case, M. D.

1/31/ 19 (Address) 2202 Gorsuch

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lloyd Ridge

DATE OF BURIAL: Jan 31 19 30

20 UNDERTAKER: W. Sutherland

ADDRESS: Route

Be DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks. 1111

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53538 — 123 — E 53538

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1101 Carroll St., 21-29 WARD)

2—FULL NAME Margaret Baker

(a) RESIDENCE NO. 1101 Carroll ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 7 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Baker

6 DATE OF BIRTH (month, day, and year): Sept 27-1849

7 AGE — Years: 80 — Months: 4 — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Chas Hellend

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Augusta Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Anna Baker

(Address) 1101 E Carroll St

15 Filed ..., 19.. ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 29-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Jan 29, 1930, that I last saw h[er] alive on Jan 29, 1930 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cholecystitis Gall Stones

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Dan Greenstein, M. D.

Jan 30 1930 (Address) 511 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Jan 31 1930

UNDERTAKER: Hafer Kirkwood Sons — ADDRESS: North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 31 1930 HAMPSON JOHNS, E... P.M.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53539 — 91-002 — E 53539

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1745 E Lafayette Ave ST. 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac Albert Bacharach

(a) RESIDENCE NO. 1745 E Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 9 mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Laura S. Bacharach

6 DATE OF BIRTH (month, day, and year) April 20 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Abraham Bacharach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Babette Bernheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U.S.

14 Informant Laura S. Bacharach

(Address) 1745 E Lafayette Ave

Filed JAN 30 1930 by HAMPSON JONES Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28th 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-27- 1929 to 1-28- 1930

that I last saw h[illegible] alive on January 21 1930

and that death occurred, on the date stated above, at 6.05 p.m.

The CAUSE OF DEATH* was as follows:

Coronary sclerosis

(duration) yrs 1 mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

acute (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of

Was there an autopsy? ~

What test confirmed diagnosis? ~

(Signed) George Elmer Bowden, M. D.

1/29 1930 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem

DATE OF BURIAL Jan 31 1930

20 UNDERTAKER L. J. Dickson & Sons

ADDRESS 1 E Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29m—L. F. S.—100 Blks.

E 53540

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 E 53540.

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Hebrew Home Hospital ST. 2754 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Aravow

(a) RESIDENCE NO. Belvedere + Greenspring ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 61 '66 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Mosis Aravow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sadie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Hospital Record

(Address)

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan-30-30

17 I HEREBY CERTIFY, That I attended deceased from Nov-15- 1929 to Jan-30- 1930, that I last saw her alive on Jan-30- 1930 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) acidosis

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel M. D.

1/30, 1930 (Address) Herman Seidel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: Jan 31, 30

20 UNDERTAKER: Sol Levinson + Bro — ADDRESS 1127 E Balto st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 31 1930 REGISTRAR'S OFFICE

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 53541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 869 W. Lombard St. 18-29 Ward)

2-FULL NAME Petronia Tautkus

(a) RESIDENCE NO. 869 W. Lombard St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Tautkus

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER George Sedlaskas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Stanley J. Tautkus
(Address) 869 W. Lombard St.

15 Filed ..., 19... Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur Feller M. D.

1/30. 1930 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOLY REDEEMER	FEB. 1. 1930
20 UNDERTAKER	ADDRESS
JOHN GRIGLIAUSKAS & CO.	423 S. PACA ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53542 38 E 53542

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 7-13 Ward)

2-FULL NAME Maurice Thomas

(a) RESIDENCE NO. 1612 Milliman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	B	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6/29

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Julius Walden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER (Aline) Bessie Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Locke (Undertaker
(Address) C. Henderson Jones, M.

15 Filed JAN 31 1930 By Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Anaemia-Congenital Leues

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1/31/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Jan 31 1930
20 UNDERTAKER Mrs J. B Locke	ADDRESS 1330 Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 53543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 ✓ E 53543

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hosp. St., 7-13 Ward)

2-FULL NAME Ethel I Gunnes

(a) RESIDENCE NO. 717 N. Caroline St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25, 1925

7 AGE: Years 4 Months 8 Days 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph I Gunnes

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Lennie Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Lennie I Gunnes

(Address) 717 N. Caroline St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest/~~inquiry~~ inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. Pneumonia -Accidental burns face body etc.. clothes caught fire from gas heater Jan 1/30

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(duration) .....yrs. .....mos. .....ds.

(Signed) John Oliver M. D. (Coroner)

1/31/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.... yrs.. mos.. ds. In the State yrs.. mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. Date of Burial: Jan 31, 1930

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS: 1715 Eastlander

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

31 1930 C. HANSON JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Blks.

Godsey

E 53544 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 53544

101-001

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 304 N Edon ST. 5-8 WARD)

2—FULL NAME James Godsey

(a) RESIDENCE NO. 304 N Edon ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Cherry Godsey

6 DATE OF BIRTH (month, day, and year) Dec 25 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gen

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Willis Godsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ida Godsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Cherry Godsey

(Address) 304 N Edon ST

15 Filed JAN 31 1930 E. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 28-30

17 I HEREBY CERTIFY That I attended deceased from Jan 22, 19..., to Jan 28, 1930, that I last saw h living on Jan 28, 1930 and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Croupous Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical

(Signed) George F. Allen, M. D.

1-29, 1930 (Address) 568 — 08

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakey County

DATE OF BURIAL Jan 31 1930

UNDERTAKER Mark A. Ellett

ADDRESS 1725 Washington

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53545

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 90 E 53545

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. President Hospital 4-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Wilson

(a) RESIDENCE NO. Washington Boulevard Howard Co. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Charles Carey (friend)
(Address) Main St Elkridge Md

15 Filed ....., 19.... Registrar

JAN 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-31-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Jan 31, 1930, that I last saw h alive on Jan 31, 1930 and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Stenosis
Myocardial Insufficiency

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) President Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laudeny Cem. DATE OF BURIAL Feb 1 1930

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

William B Smith ✓ 90 E 53546

E 53546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 9-46

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 152 Abbottston ST., 9-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William B Small

(a) RESIDENCE NO. 152 Abbottston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 29 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John A Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ida Gentry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William A Smith

(Address) 152 Abbottston

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

JAN 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30/30

17 I HEREBY CERTIFY, That I attended deceased from 1/26, 1930, to 1/30/30, 19..., that I last saw him alive on 1/30/30, 19..., and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurg. c

Bronchial Pneumonia.

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY

(Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard J. Terry, M. D.

1/30/30 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkton Va	Jan 31 1930
20 UNDERTAKER Vernon Teehner	ADDRESS 153 Hollins

OF DEATH in plain terms, so that it may be properly classified. State relationship of occupation if any important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53547 — 91-02 — E 53547

CERTIFICATE OF DEATH

REGISTERED NO. 13-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2428 Callow Ave. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Keyser Rosenberg

(a) RESIDENCE NO. 2428 Callow Ave ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Rosenberg

6 DATE OF BIRTH (month, day, and year) Aug 29, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Moses Keyser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bettie Reiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Pretzel (Address) 2428 Callow Ave.

15 Filed 1-31 1930 to C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan, 19 25, to Jan 31, 19 30, that I last saw h[illegible] alive on Jan 31, 19 30 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I Frederick Lutz, M. D.

1-31, 1930 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 2/2/1930

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1133/53548

CERTIFICATE OF DEATH

X 101-001

E 53548

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida May Ferber

(a) RESIDENCE NO. Washington D C ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Feb 21 - 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): 0 0

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Wash D C

PARENTS

10 NAME OF FATHER: Raymond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wash D. C.

12 MAIDEN NAME OF MOTHER: Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JAN 31 1930 19 H. M. JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan. 30, 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Jan. 30, 1930, that I last saw her alive on Jan 30, 1930 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Bilateral pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) John Hopkins, M. D.

(Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington, D.C.

DATE OF BURIAL: Jan 31, 1930

20 UNDERTAKER: John D. Mitchell & Sons

ADDRESS: 1900 E. Lexington St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53549

CERTIFICATE OF DEATH.

31 E 53549

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2527 Edmondson Ave 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Frederick Margraf, Jr

(a) RESIDENCE NO. 2527 Edmondson Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Nellie Frances Margraf

6 DATE OF BIRTH (month, day, and year) Dec-18-1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Beef Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Kaufman Packing Co,

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Frederick Margraf

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Mc Namee

13 BIRTHPLACE OF MOTHER (city or town) Boston

(State or country) Mass.

14 Informant Nellie F. Margraf

(Address) 2527 Edmondson Ave

FILED 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan-30 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov-12- 1929, to January 30, 1930, that I last saw h.im alive on January 29, 1930, and that death occurred, on the date stated above, at 8:45a m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Laryngeal Tuberculosis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of?

Was there an autopsy? no

What test confirmed diagnosis? Sputum & X-ray

(Signed) Chester Ruland, M. D.

1-30 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Date of Burial 2/3/1930

20 UNDERTAKER Em. Fisher & Son ADDRESS 2503 Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 3

Spec.—1-30—M. & T.—250 Blks.

108 E North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 53550 E 53550

CERTIFICATE OF DEATH.

49

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Greenway Apts

CITY OF BALTIMORE: (NO. Chas + 34th ST. 12-49 WARD)

2-FULL NAME Willie Nicks Earle

(a) RESIDENCE NO. Greenway Apts Chas + 34th St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Wm B Earle

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Nicks

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Matilda Real.

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs B. Earle
(Address) Greenway Apts.

15 Filed JAN 31 1930, 19.. C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929, to Jan 30, 1930, that I last saw h[illegible] alive on Jan 30, 1930, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Spinal Column.

(duration) 1 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? X.R.T. Diagnosis

(Signed) [illegible] —, M. D.

, 19 (Address) 108 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Centreville Md

DATE OF BURIAL 2/1 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 1 1930

Spec.—2-29-28—L. F. S.—600 Blks.

E 53351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 53351

REGISTERED NO. 27-40

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5413 Catalpha Road ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothy M. Herpel

(a) RESIDENCE NO. 5413 Catalpha Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Herpel

6 DATE OF BIRTH (month, day, and year) July 6th 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59 60	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John A. Rulle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Anna M. Pizzi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant William H. Herpel

(Address) 5413 Catalpha Road.

15 G. HAWSON JONES, M. D. Registrar

FEB 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 15, 1929, to Jan 29, 1930, that I last saw h[illegible] alive on Jan 29, 1930 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia & Arthritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests

(Signed) Elbert Singmaster M. D.

1930 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Cemetery	Feb. 1st 1930
UNDERTAKER Lilly & Feiler Inc	ADDRESS 405 N. Wolfe St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 53552

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53552

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp ST. 15-bb (WARD)

2-FULL NAME Margaret D. Flippin

(a) RESIDENCE NO. 3028 Windsor Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs — mos — da. How long in U. S., if of foreign birth? yrs mos da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew S. Flippen,

6 DATE OF BIRTH (month, day, and year) July 9. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	63	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Mfr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas S Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Pollard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Pearl L. Stevenson

(Address) 3028 Windsor Ave

15 C. HAMPSON JONES, M. D. Registrar

Jan 31 1930 By AKA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Jan 29, 1930, that I last saw her alive on Jan 29, 1930 and that death occurred, on the date stated above, at 5 P m

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis (duration) 2 yrs. mos da.

(over)

CONTRIBUTORY (Secondary) Respiratory Failure (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) S. A. Alexander, M. D.

, 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Feb 1st 1930

20 UNDERTAKER Geo W Sittler

ADDRESS 2700 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53553

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53553

CERTIFICATE OF DEATH

21

1—PLACE OF DEATH Baltimore City Hospitals (Tbc. 3-4) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Sharp

(a) RESIDENCE NO. 610 N. Spring st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
23	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 FILED JAN 31 1930, 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 16, 1929, to Jan. 26, 1930, that I last saw him alive on Jan. 26, 1930 and that death occurred, on the date stated above, at 8.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis: Clinical

(Signed) Jas Sharpe M. D.

1-27-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS JAN 31 1930

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53554 100-09 E 53754

CERTIFICATE OF DEATH

E 53554

1-PLACE OF DEATH

City of Baltimore: (No. 1114 China St. St.) 21-3 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Height.(C)

(a) RESIDENCE NO. 1114 China St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 11, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	4	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None. 0 0
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward Height.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Calvert Co. Md.

12 MAIDEN NAME OF MOTHER Mary Hurley.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co. Md.

14 Informant Mary Height.(C) mother.
(Address) 1114 China St.

15 Filed JAN 31 1930 19 C. HAMPSON JONES, M. D. Registrar

4317

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 29th. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held on inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas. M. Leonard, M. D.

1/30, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Board of Health.

ADDRESS JAN 31 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53555 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 44 E 53555

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4603 Keswick Road ST. 27-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amanda L. Spencer

(a) RESIDENCE NO. 4603 Keswick Road ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) do.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER James P. Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Mary E. Spencer
(Address) 4603 Keswick Road

15 Filed JAN 31 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30-1930

17 I HEREBY CERTIFY, That I attended deceased from April 1929 to Jan 29 1930

that I last saw h er alive on Jan 29 1930

and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 5 mos. 29 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical Examination

(Signed) C. J. Davies, M. D.

1-30 1930 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hamden	Feb. 1-1930.
20 UNDERTAKER	ADDRESS
Horace H. Burgee	3631 Falls Road

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hds.

SWEM

E 53556

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001 E 53556

CERTIFICATE OF DEATH.

REGISTERED NO. 27-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 4509 Schenley Road ST. WARD

2-FULL NAME Evelyn E. Swem

(a) RESIDENCE NO. 4509 Schenley Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 6 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 26-1911

7 AGE: Years 18 Months 6 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Walter D. Swem

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth C. Moorman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Walter D. Swem

(Address) 4509 Schenley Road

15 1 31 1930

C. H. IMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/31 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, to 1/31, 1930,

that I last saw h alive on 1/30 - 12 P.M. 1930,

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pleuro Pneumonia Influenza -

(over)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis, Pulmonary

Increasing Dyspnoea 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry T. Eppley, M. D.

1/31, 1930 (Address) Maryland Ave & 39th St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Feb 3, 1930

20 UNDERTAKER: Horace K. Burgee

ADDRESS: 2 Park Road

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—2-20-28—[illegible] S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53557

CERTIFICATE OF DEATH

111-001 ✓ E 53557

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (WARD) 10-14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Ring

(a) RESIDENCE NO. 1011 Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18 1864

7 AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
65	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Ring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address)

15 Filed JAN 31 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30-30

17 I HEREBY CERTIFY, That I attended deceased from 1-27, 1930, to 1-30, 1930, that I last saw h[illegible] alive on 1-30, 1930 and that death occurred, on the date stated above, at 11[illegible] a. m.

The CAUSE OF DEATH* was as follows:

Cachexia ulcer

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Perforated ulcer - Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 1-27-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. A. Crumpton, M. D.

1-31, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Feb 1, 1930

20 UNDERTAKER Edmund W. Conklin

ADDRESS 924 E. Eager St.

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 53558 E 53558

CERTIFICATE OF DEATH.

88

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Sargeant St.) (WARD) 21-29

2-FULL NAME Lucy Jennie Rahn

(a) RESIDENCE No. 1104 Sargeant ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas Rahn

6 DATE OF BIRTH (month, day, and year): 12/13/1869

7 AGE: Years 60 61; Months 1m; Days 16; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lurgen City Pa

PARENTS

10 NAME OF FATHER: Geo Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Chas Rahn 1104 Sargeant St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1/29/30 19

17 I HEREBY CERTIFY, That I attended deceased from Jany 22, 1930, to Jan 29 - 1930, that I last saw her alive on Jan. 29, 1930, and that death occurred, on the date stated above, at 7 pm

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis? Clinical

(Signed) M. B. Frilinger M.D.

1-30 1930 (Address) 682 Wash Blvd Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 2/1/30 19

20 UNDERTAKER: Geo Lenhard & Son

ADDRESS: 620 N. Lynnhurst

JAN 31 1930 C. THOMPSON JONES, M. D. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53559 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 53559**

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO. 1-30

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin Eicholtz

(a) RESIDENCE NO. Phoenix, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Marion Eicholtz

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Eicholtz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Martin Eicholtz
(Address) Phoenix Md

15 Filed JAN 31 1930 C. H. IMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 31, 1930, that I last saw him alive on Jan 31, 1930, and that death occurred, on the date stated above, at 4.05 P.m.

The CAUSE OF DEATH* was as follows:

Perforated gastric ulcer

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Phoenix Md.

Did an operation precede death? Yes Date of Jan 29, 1930.

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) George A. Geyer, M. D.

Jan 31, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cremation, Balto. Co., Md	Feb 3 1930
20 UNDERTAKER	ADDRESS
Com. C. Brockerhoff	Hanover Md

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blu.

E 53560

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53560

CERTIFICATE OF DEATH

48

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Gelston Drive ST., 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nora A. Short

(a) RESIDENCE NO. 701 Gelston Drive ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene F. Short

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	64	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER ------- Daley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not obtainable

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Eugene F. Short

(Address) 701 Gelston Drive

15 Filed 1930 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1930, to Jan 30, 1930

that I last saw her alive on Jan 29, 1930

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion from long illness - Carcinoma of face

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Assumed

(Signed) A R Gosnell, M. D.

1/31, 19 (Address) 11 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 2/1 1930

UNDERTAKER Henry V. Mears & Son

ADDRESS 845 N. Calvert

N 3 1 1930

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53561

CERTIFICATE OF DEATH

24-091

E 53561

1-PLACE OF DEATH

City of Baltimore: (No. 409 Conway St. 21-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman C. Klatt

(a) RESIDENCE NO. 307 Scott St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Valentina Klatt

6 DATE OF BIRTH (month, day, and year) April 7-1850

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	79	9	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Martin Klatt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. E. K. Klatt
(Address) 307 Scott St

15 DEC 1 1930 C. H. THOMPSON JONES, M. D. Registrar

Filed DEC 3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fellers, M. D.

12/31, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Feb. 3 1931

20 UNDERTAKER Harry N. Weitzke, 4101 Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 3

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53562

90 E 53562

CERTIFICATE OF DEATH

REGISTERED NO. 27-48

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4662 Kernwood Ave. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anne C. Flaherty

(a) RESIDENCE NO. 4662 Kernwood Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph V. Flaherty

6 DATE OF BIRTH (month, day, and year) August 12, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edwin Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph V. Flaherty

(Address) 4662 Kernwood Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Jan 30, 1930, that I last saw h alive on Jan 29, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatism

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Valvular Disease of Heart

(duration) - yrs. - mos. 10 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

1/31, 1930 (Address) 512 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL Feb. 1/30

20 UNDERTAKER Harry N. Fritzlen 4191 Edmondson Ave.

ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901 ✓

E 53563

CERTIFICATE OF DEATH

E 53563

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2554 W. Lombard St. 7019 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Baker Elston

(a) RESIDENCE NO. 2554 W. Lombard St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 3, 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Elston

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Belle Singhass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles Elston

(Address) 2554 W. Lombard St.

15 1 31 1930, 19 C. H. PARKSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/30/30

17 I HEREBY CERTIFY, That I attended deceased from 1/28, 1930, to 1/30/30, 19....

that I last saw h— alive on 1/30/30, 19....

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

History

(duration) yrs. mos. 2 da.

CONTRIBUTORY History wks pneumonia almost 1 wk.

(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. Exam.

(Signed) Bernard J. Terry, M. D.

1/31, 1930 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olive Cem. Randallstown

DATE OF BURIAL: Feb. 2/30

20 UNDERTAKER Harry N. Witzke, 410 Edmondson Ave.

ADDRESS

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53564

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

E 53564

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 42-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2828 Huntingdon Ave. ST. 42 WARD)

2—FULL NAME Joseph Smith.

(a) RESIDENCE NO. 2828 Huntingdon Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Smith.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Alban.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Charles Smith.
(Address) 2828 Huntingdon Ave.

15 Filed JAN 31 1930, 19 C. H. THOMPSON JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 19 30, to Jan 30, 19 30,
that I last saw alive on Jan. 29, 19 30
and that death occurred, on the date stated above, at 12:17 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Catarrh
Exhaustion. Pneumonia

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. R. Miller M. D.

1/31/30 (Address) 2757 W. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Lorraine Park.

DATE OF BURIAL
Feb 2, 1930

(2) UNDERTAKER Thomas Wilson Sons

ADDRESS 3645 Eastern Ave

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53565

99-001 ✓

E 53565

CERTIFICATE OF DEATH

REGISTERED NO. 13-52

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4009 Evans Chapel Road WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph E. Frantom.

(a) RESIDENCE NO. 4009 Evans Chapel Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie B. Frantom.

6 DATE OF BIRTH (month, day, and year) Aug 9, 1858.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Frantom.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jane Hume.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Annie B. Frantom.

(Address) 4009 Evans Chapel Road.

15 FILED 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 24, 1930, to Jan. 30, 1930, that I last saw h[illegible] alive on January 29, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Pulmonary Congestion (Hypostatic) Chronic Bronchitis

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) [illegible], M. D.

. 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Taylorsville Carroll Co.

DATE OF BURIAL Feb 3, 1930

20 UNDERTAKER Edmondson Sons

ADDRESS 3615 Edmondson Ave

Important. See instructions on back of certificates.

Spec.—7-30—M. & T.—250 Bks.

E 53566 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 53566

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1013 Frederick Ave

CITY OF BALTIMORE: (NO. ..... ST. 70-71 WARD)

2-FULL NAME Rosa Saladino

(a) RESIDENCE NO. 1013 Frederick Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Switzerland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Switzerland
(State or country)

12 MAIDEN NAME OF MOTHER Bertha —

13 BIRTHPLACE OF MOTHER (city or town) Switzerland
(State or country)

14 Informant Louis Yeatman
(Address) 1013 Frederick Ave

15 Filed JAN 31 1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 19 28, to Jan 31, 19 1930
that I last saw h~ alive on Jan 30, 1930
and that death occurred, on the date stated above, at 8:55 a. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. 11 mos. 11 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical examination

(Signed) Jos. L. Straus M. D.
1/31/30 (Address) 1729 K Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Jan 19

20 UNDERTAKER Wm Cook — ADDRESS 1217 N Gay St

TION is very important. See instructions on back of certificates.

Rev.—8-16-29—L. F. S.—100 Bks.

E 53567 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 53567.

1—PLACE OF DEATH

REGISTERED NO. 13-54

CITY OF BALTIMORE: (No. 723 Reservoir ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles T. Davis.

(a) RESIDENCE NO. 723 Reservoir ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Edith Dorsey

6 DATE OF BIRTH (month, day, and year) Oct 2, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington DC (State or country)

PARENTS

10 NAME OF FATHER Geo Davis

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Harriet Keen

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs Chas T Davis

(Address) 11 Pauline 28th St

15 FILED FEB 1 - 1930 C. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1930

17 I HEREBY CERTIFY That I attended deceased from 1925 to Jan. 31 1930

that I last saw h living on Jan. 30 1930

and that death occurred on the date stated above, at 12.15 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) Geo M Little, M. D.

1/31 1930 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 1 1930

20 UNDERTAKER and Fitzhugh Mitchell Son ADDRESS 1910 Eutaw

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 53568

HEALTH DEPARTMENT—CITY OF BALTIMORE E 53568

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2323 Fayette St. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Michel

(a) RESIDENCE NO. 2323 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 1 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
BUSBAND of
or) WIFE of Peter Michel

6 DATE OF BIRTH (month, day, and year) Dec. 6, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	72	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Antone Strasler

11 BIRTHPLACE OF FATHER (city or town) Not known
(State or country) (Germany)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Germany

14 Informant Mr. Peter Michel
(Address) 2323 E Fayette St

15 Filed FEB 1 1930 H. LAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31, 1930

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to Jan 31, 1930,

that I last saw her alive on Jan 31, 1930,

and that death occurred, on the date stated above, at 7.08 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with hypertension

(duration) yrs 10 mos 16 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation with Anasarca (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Chas Wm Edmunds, M. D.

, 19 (Address) 2746 Alameda Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Feb 3 1930

20 UNDERTAKER John Ulmer

ADDRESS 2[illegible] Aliceanna

CAUSE OF DEATH must be plainly written, so that it may be properly classified. DATE OF DEATH must be filled in. ATTENDING PHYSICIAN'S CERTIFICATE is very important. See instructions on back of certificates.

Rev. 1-10-21 MAT 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53569

CERTIFICATE OF DEATH.

90 ✓ E 53569

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3301 Southern Ave (Ward) 27th

2-FULL NAME Charles Bausch

(a) RESIDENCE NO. (Usual place of abode) 3301 Southern Ave WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 15/1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
72	73	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chris Bausch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine — —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Minnie Lefevre

(Address) 3301 Southern Ave

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from February 26 to Jan. 29. 1930.

that I last saw h.. alive on Jan. 25. 1930.

and that death occurred, on the date stated above, at 8.45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

over (duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. M. Bacon, M. D.

1/2, 1930 (Address) Parkville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL Feb 1 1930

UNDERTAKER Philip Henrig

ADDRESS 2016 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 1 1930 C. HAMPSON JONES, M.

Spec.—1-12-23—M&T—500 Blks.

E 53570 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 53570

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 4604 Kavon Ave

CITY OF BALTIMORE: (No. ..... ST. 26-41 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna A. Krill

(a) RESIDENCE NO. 4604 Kavon Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 45 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Peter Krill

6 DATE OF BIRTH (month, day, and year) May 14, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. M. Ezring
(Address) 4604 Kavon Ave

15 Filed ... 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 1929, to Jan. 29, 1930, that I last saw h[illegible] alive on Jan. 30, 1930, and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall-Bladder

(duration) 1 yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) L. C. Sobbel, M. D.

1/30, 1930 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Feb. 1 1930

20 UNDERTAKER Philip Herring

ADDRESS 2016 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly coded. ... TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53571

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53571

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH Baltimore City Hospitals 6-9 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Bauers

(a) RESIDENCE NO. 114 N. Dallas St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bauers

6 DATE OF BIRTH (month, day, and year) May 8, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72 ?	9	22 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Justice Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Eliz. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Baltimore City Hospitals

Filed 1-1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-31-30

17 I HEREBY CERTIFY, That I attended deceased from 1-28-30, 19..., to 1-31-30, 19...,

that I last saw h e alive on 1-31-30, 19...

and that death occurred, an the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows: Myocarditis, Chronic & acute

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

1-31, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. A. Garner

DATE OF BURIAL Feb 3 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53572

CERTIFICATE OF DEATH

167 001 E 53572

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 202 Edew St., 3-5 Ward)

2-FULL NAME Charles Horton

(a) RESIDENCE NO. 202 Edew St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	about 38.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Horton Norway

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Horton Norway

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Horton Norway

14 Informant Records in Home
(Address)

15 Filed FEB 1 - 1930 16 HAMPSON JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Gas Poisoning, Ill.

(duration) 1 yrs. mos. — da.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. — da.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) G. E. Gladden, M. D.

(Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem DATE OF BURIAL Feb. 1 1930

20 UNDERTAKER Wendel J. Heppel ADDRESS 300 E. Eager St.

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53573 HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓E 53573

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division St. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Diego Diaz

(a) RESIDENCE NO. 1403 Druid Hill Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored Porto Rican	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Omer Diaz

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Porto Rico (State or country)

PARENTS

10 NAME OF FATHER Samuel Diaz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Porto Rico

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Omer Diaz

(Address) 1403 Druid Hill Ave

15 FEB 1 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30-30

17 I HEREBY CERTIFY, That I attended deceased from 12-1-29, 19..., to 1-30-30, 19...,

that I last saw h~~e~~ alive on Jan 30, 1930

and that death occurred, on the date stated above, at 4½ a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2yrs 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? ~~no~~ Date of —

Was there an autopsy? ~~no~~

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 2/1/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 53574

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 53574

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 325 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo C Holdorf

(a) RESIDENCE NO. 1044 Granby St., 4 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. 0mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Holdorf

6 DATE OF BIRTH (month, day, and year) Oct. 15th 1868

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
60	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Casper Holdorf

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz Schmitker

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Annie Holdorf
(Address) 626 S Ellwood Ave

15 Filed JAN 31 1930 19 C. H. LEMPSON JOHNS, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) P E Blades, M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem — DATE OF BURIAL: Feb 1st 1930

20 UNDERTAKER: Lilly & Zeller Inc — ADDRESS: 403 S Wolfe St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B

Cor.—10-10-29—A Co.—100 Bks.

E 53575

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 53575

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Sinai Hospital St., 7-12 Ward)

2-FULL NAME J. Howard Irving

(a) RESIDENCE NO. 702 N.Glover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Maried

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Irving

6 DATE OF BIRTH (month, day, and year) July 4/1887

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	42	6 8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chipper 086
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Rexford Iron Works

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. A. Irving

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Annie Irving (Wife)
(Address) 702 N.Glover St

15 Filed ..., 19... Registrar

1930 C. Miller Supt. V.S., M. D. C.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 29/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ...yrs. ...mos. 21 ds.

CONTRIBUTORY (Secondary) Healed Cavity in upper lobes both lungs (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Sinai

What test confirmed diagnosis?

(Signed) J. H. Irving, M. D.

2/1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL 2/1 1930

20 UNDERTAKER J. J. Moran

ADDRESS 3000 E Balto.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 53576

Frances Rykaczewska

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 53576

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 230 S. Ann Street 2-4 Ward)

2-FULL NAME Frances Rykaczewska

(a) RESIDENCE NO. 230 S. Ann Street St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ignacy Rykaczewski

6 DATE OF BIRTH (month, day, and year) April/1/1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Peter Krowczynski---Son.

(Address) 2014 Gough Street

15 1930 C. H. Thompson Jones, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH 1/30/30

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: 10 P.M.

Chr Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY Bronchial Comp

(Secondary)

(duration) yrs. mos. ds.

1/3 (Signed) C. C. Lally M. D.

(Coroner)

, 192 (Address) 1430 Bury

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St, Stanislaus Cemetery Date of Burial Feb 3 1930

20 UNDERTAKER George A. Weber ADDRESS 705 S. Ann St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

E 53577 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53577

CERTIFICATE OF DEATH.

151

1-PLACE OF DEATH — REGISTERED NO. C .....

CITY OF BALTIMORE: (No. 717 Ramsey St. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Stolzenbach

(Residence in Baltimore: No. 717 Ramsey St.; 60 yrs., 7 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): widower

6-DATE OF BIRTH: June (Month) 21 (Day), 1869 (Year)

7-AGE: 60 yrs. 7 mos. 10 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoe factory Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Shoe

9-BIRTHPLACE, (State or Country): Baltimore md

PARENTS.

10-NAME OF FATHER: George H. Stolzenbach

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Lydia C. Schmidt

(Address): 717 Ramsey St.

FEB 1 - 1930

Filed....., 191.... C. HAMPSON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: Jan (Month) 31 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1 1929, to Jan 31 1930 that I saw h im alive on Jan 31 1930 and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

..... (Duration) ....yrs. 7 mos. ....ds.

CONTRIBUTORY (Secondary) None

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. Braxton Jones, M. D.

2/1/30, 191... (Address) 888 N. Longwood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cem

DATE OF BURIAL: Feb 3, 1930

20-UNDERTAKER: Jos Joerdens Son

ADDRESS: 2078 Pres

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

E 53578 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53578

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2553 Hollins 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth A. Michael

(Residence in Baltimore: No 2553 Hollins St.; 89 yrs., 11 mos. 13 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Feb (Month) 13 (Day), 1840 (Year)

7-AGE, 89 yrs. 11 mos. 13 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore md

PARENTS.

10-NAME OF FATHER, Thomas S. Allen

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William B. Michael

(Address) 2553 Hollins

FEB 1 - 1930 C. HAMPSON JONES

Filed ..... 191.. By .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 30 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 11 1930, to Jan 30 1930, that I saw h[illegible] alive on Jan 30 1930, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....da.

(Signed) Everett R Allen M. D.

1/31/30, 192.. (Address) 3004 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet Cem. DATE OF BURIAL, Feb 3, 1930

20-UNDERTAKER Jos Jacobs ADDRESS 2173 E. Pr

Important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53579

CERTIFICATE OF DEATH

X 11-001V

E 53579

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. 327 D Fremont St.) 22-30 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Boyd

(a) RESIDENCE NO. 327 D. Fremont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs 5 mos. ds. How long in U. S. if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Winnsboro, (State or country) South Carolina

PARENTS

10 NAME OF FATHER George Boyd

11 BIRTHPLACE OF FATHER (City or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Maggie Ford

13 BIRTHPLACE OF MOTHER (city or town) Winnsboro (State or country) S. C.

14 Informant Matthews Boyd

(Address) 327 D. Fremont Ave.

Filed FEB 1 1930 H. LEE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 30, 1930, to Jany 31, 1930, that I last saw h[illegible] alive on Jany 30 1930, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Headen M. D.

1/31, 1930 (Address) 642 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Winnsboro, S. C.	Feb. 1, 1930
20 UNDERTAKER	ADDRESS 372 1
Mrs. Lettie R. Williams	Schroeder St

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53580 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53580

15

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5924 Marlyth Ave ST. 26-42 WARD)

2-FULL NAME Robert Melcher

(a) RESIDENCE NO. 5924 Marlyth Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Melcher

6 DATE OF BIRTH (month, day, and year) March 5th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible] 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hessen Kassel Germany

PARENTS

10 NAME OF FATHER Henry Melcher

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Germany

14 Informant Anna Melcher (Address) 5924 Marlyth Ave.

15 Filed ....., 19 .....

C. HAMPSON JONES, M.D. Registrar

Per .....

EBT - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 30th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1929, to Jan 30, 1930, that I last saw him alive on Jan 30, 1930, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Erythema Multiforme

(duration) ... yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. L. Williamson, M. D.

1/31, 1930 (Address) 5713 Belvidere Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Feb. 3 1930

20 UNDERTAKER Frederick Leachman — ADDRESS Lonaconing

FROM A VERY important. See instructions on face of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53581

CERTIFICATE OF DEATH

202 / E 53581

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Jackson

(a) RESIDENCE NO. Maryland Penitentiary WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie May Jackson

6 DATE OF BIRTH (month, day, and year) Apr 2 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) District of Columbia

PARENTS

10 NAME OF FATHER William Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sally (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Md. Penitentiary Records

(Address) Maryland Penitentiary

15 Filed FEB 1 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 23, 1929, to Jan 31, 1930

that I last saw him alive on Jan 31, 1930

and that death occurred, on the date stated above, at 12 10 A m.

The CAUSE OF DEATH* was as follows:

Fracture of Cervical Vertebrae

Hanged by Order of Court

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Joshua A. Armacost, M. D.

Jan 31, 1930 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. DATE OF BURIAL Feb. 1st 1930

20 UNDERTAKER Mason Ida Snowden ADDRESS 845 Edmondson Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53582

CERTIFICATE OF DEATH

REGISTERED NO. 153 E 53582

E 53582

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 Division ST., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles W Robinson

(a) RESIDENCE NO. 1705 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Mary C Robinson

6 DATE OF BIRTH (month, day and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wesley Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rosie Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary B Robinson

(Address) 1205 Division

15 Filed 1-31-1930 C. HAMPSON JONES Registrar

EBT - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/29/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930 to Jan 29, 1930

that I last saw him alive on Jan 29, 1930

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Auto Lesions

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Perineal abscess

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) John H. Hoffman M. D.

19 (Address) 1012 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 1-31 1930

20 UNDERTAKER David Easton

ADDRESS 515 Park

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 53583

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53583

CERTIFICATE OF DEATH

167-001

1-PLACE OF DEATH

City of Baltimore: (No. 212 N. Wolfe St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine L. Jenkins

(a) RESIDENCE NO. 212 N. Wolfe St., Ward

(Usual place of abode) (If non-resident give rity or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. da. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. J. Jenkins

6 DATE OF BIRTH (month, day, and year) Feb 19/1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (rity or town)
(State or country) Hagerstown, Md

PARENTS

10 NAME OF FATHER John A. Glass

11 BIRTHPLACE OF FATHER (rity or town)
(State or country) Bellville, Pa.

12 MAIDEN NAME OF MOTHER Mary Emerson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Boonesboro, Md.

14 Informant Mary Glass (Mother)
(Address) 1900 N. Collington Ave

15 Filed FEB 1 - 1930 19 C. HARRISON JONES, Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ill. Gas Asphixiation (Gas Heater)

Suicide

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contrarted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. H. Owen, M. D.

1/31/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Rose Hill Cem. Hagerstown, Md

DATE OF BURIAL Feb 2 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 1-10-21—M&T—1500 Bks.

E 53584

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53584

CERTIFICATE OF DEATH.

REGISTERED NO. 24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Harlem Ave St., E. or W.) 11-22 WARD)

2-FULL NAME Mrs. Ella Amanda Burnett

(a) RESIDENCE NO. 1500 Harlem Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 23, 1842

7 AGE — Years: 87 — Months: 8 — Days: 5 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Willow Grove N J

PARENTS

10 NAME OF FATHER: John Hetzell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eleanora Alburger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila Pa

14 Informant (Address): Raymond E Burnett 1506 Harlem Ave

15 Filed FEB 1 1930 C. HAMPSON JONES, M. D. Registrar Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1929 to Jan. 30, 1930. that I last saw her alive on Jan. 30, 1930. and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Allen A. Lorsch M. D.

Feb 1, 1930 (Address) 3705 Liberty Hts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fernwood Cemetery Phila Pa

DATE OF BURIAL: Feb 3 1930

UNDERTAKER: George J. Smith

ADDRESS: Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53585 HEALTH DEPARTMENT—CITY OF BALTIMORE 1-001 E 53585

CERTIFICATE OF DEATH

REGISTERED NO. 1-91

1—PLACE OF DEATH Balto. City Hospitals

CITY OF BALTIMORE: (No. 425 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Timothy Kennedy

(a) RESIDENCE NO. 117 N. Green ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Feb. 24, 188[illegible]

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42? or 45?	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer Albert Gumple

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Timothy J. Kennedy

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Kelly

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed [illegible], 19[illegible] C. HAMPSON JONES, Registrar

EBT - 1930 By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-31-30

17 I HEREBY CERTIFY, That I attended deceased from 1-22-30, 19..., to 1-31-30, 19...,

that I last saw him alive on 1-31-30, 19...

and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

Aneurysm of Aorta (WaR: neg.)

(duration) over 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infarct of Heart

(duration) 3 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray: Autopsy

(Signed) Herman M. Biggs, M. D.

2-1, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feby 3 1930
20 UNDERTAKER	ADDRESS
John F. Cowan & Son per Hellman Jr.	

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53586 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 ✓ E 53586

CERTIFICATE OF DEATH

1—PLACE OF DEATH 1603 E Biddle St Home REGISTERED NO. 8-13

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Nina C Bowers.

(a) RESIDENCE NO. 1603 E Biddle St ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Bowers

6 DATE OF BIRTH (month, day, and year) Aug 10th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Calvin P Holbrook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Waltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Calvin P Holbrook

(Address) 1603 E Biddle St Balto

15 Filed FEB 1 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1-1930

17 I HEREBY CERTIFY, That I attended deceased from August, 1929, to Feb 1, 1930

that I last saw h alive on Jan 31, 1930

and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis.

Aug 1929 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W Wallace Walker M. D.

, 19 (Address) 910 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hope Cemetery Woodlawn

DATE OF BURIAL Feb 4th 1930

20 UNDERTAKER Powell & Albaugh

ADDRESS Woodlawn Md

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53587 E 53587

CERTIFICATE OF DEATH

× 45 ✓

REGISTERED NO. 425

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Lord Baltimore Hotel ST. ——— WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Nora Quatman

(a) RESIDENCE NO. Sidney, Ohio ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

Important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George B. Quatman

6 DATE OF BIRTH (month, day, and year) Feb. 14, 188

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Springfield

(State or country) Ohio

PARENTS

10 NAME OF FATHER Philip Minnigan

11 BIRTHPLACE OF FATHER (city or town) Lewistown

(State or country) New York

12 MAIDEN NAME OF MOTHER Ann K. Zeigler

13 BIRTHPLACE OF MOTHER (city or town) Springfiel

(State or country) Ohio

14 Informant George B. Quatman

(Address) Sidney, Ohio

15 2-1930 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to Feb 1, 1930, that I last saw h[e] alive on Jan 29, 1930 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sidney Ohio

Did an operation precede death? yes Date of About 1 yr ago

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Leonard E Beach, M. D.

, 19 (Address) 2329 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sidney, Ohio

DATE OF BURIAL 2/2 1930

20 UNDERTAKER Henry H. Meares and Son

ADDRESS 805 N. Calvert

Via Penn. Railroad Escort - George B. Quatman

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53588 E 53588

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hosp REGISTERED NO. +101-09

CITY OF BALTIMORE: (No. Fayette & Calhoun ST., 14-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Earnest Parker

(a) RESIDENCE NO. Hamilton Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Pearl Goldman Parker

6 DATE OF BIRTH (month, day, and year) not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dallas Co, Md
(State or country)

PARENTS

10 NAME OF FATHER Nicholas Parker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Nelson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Ernest Parker

(Address) Hamilton, Md.

Filed FEB 2 1930 C. HAMPSON JONES, M.D. Registrar

By NPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Feb 1, 1930, that I last saw h. alive on Feb 1, 1930, and that death occurred, on the date stated above, at 5:35 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. 0 mos. 28 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) N B Schreiber, M. D.

, 19 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St James, Hamilton, Md

DATE OF BURIAL Feb 4 1930

20 UNDERTAKER Wm. C. Burdette & Son

ADDRESS Govans, Md.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53589

E 53589

CERTIFICATE OF DEATH.

49

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Catholic r ohan Sts 47-19 WARD)

2-FULL NAME John Peterson

(a) RESIDENCE NO. 439 E. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Mary E. Peterson

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	75	—	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer

9 BIRTHPLACE (city or town) York Pa
(State or country)

PARENTS

10 NAME OF FATHER Daniel Pearson

11 BIRTHPLACE OF FATHER (city or town) York Pa
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant ..... (Address) York Pa

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-31 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-11, 1929, to 1-31, 1930.

that I last saw him alive on 1-31, 1930,

and that death occurred, on the date stated above, at 7 05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Unknown (duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia General Carcinomatosis

(duration) ... yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Unknown 12-21-29

Did an operation precede death? yes Date of 1-28-30.

Was there an autopsy? no operation + Laboratory

What test confirmed diagnosis? autopsy.

(Signed) M. Blackwell, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feb 3 1930

20 UNDERTAKER Mary W. Medefind

ADDRESS 39 E 22nd St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2 -1930

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53590

CERTIFICATE OF DEATH.

E 53590

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S Smallwood St. W-6th)

2-FULL NAME Frances E Hood W

(Residence in Baltimore: No. 319 S Smallwood. St.; 5 yrs., ... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Widower

6-DATE OF BIRTH, ... 2 (Month) ..... 21 (Day), 1865 (Year)

7-AGE, 64 yrs. 11 mos. 9 da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pipe fitter
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country). Harford Co

PARENTS.

10-NAME OF FATHER, Frank Hood

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER Frances Goldard

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Chas Hood

(Address) 206 Bond St

15-

Filed ....., 191.... Registrar.

C. HAMILTON JONES, M. D.

2 - 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, January 30, 1930
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Jan 14 1930. to Jan 30 1930.
that I saw ~~him~~ alive on Jan 30 1930.
and that death occurred, on the date stated above, at 9 a. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Myocarditis & Nephritis
(Duration) Months Indefinite

CONTRIBUTORY (Secondary) Pulmonary Edema
(Duration) ..... yrs. ..... mos. 1 da.

(Signed) Norton C Nelson M. D.
Jan 31, 1930 (Address) 215 W Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery — DATE OF BURIAL, Feb 3, 1930

20-UNDERTAKER Mary M. Wendelken — ADDRESS 201 E 22nd

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53591

CERTIFICATE OF DEATH

101-001

E 53591

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St. 16-23 Ward

2-FULL NAME Wilbur Luckett

(a) RESIDENCE NO. 1106 Mosher St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: No.

6 DATE OF BIRTH (month, day, and year): May - 1929

7 AGE: Years | Months: 10 | Days: — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country):

PARENTS

10 NAME OF FATHER: Unknown,

11 BIRTHPLACE OF FATHER (city or town): Baltimore
(State or country):

12 MAIDEN NAME OF MOTHER: Gertrude Luckett

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country): Md.

14 Informant: Geo. W. Luckett
(Address): 1106 Mosher

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest Autopsy (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. Leo Lucke M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: Feb 3 1930

20 UNDERTAKER: Samuel Hemsley

ADDRESS: 1178 W Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 53592 100-001 E 53592

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Provident Hospital ST., 9-27 WARD)

2—FULL NAME Blanche Neal

(a) RESIDENCE NO. 402 P Smith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant John Neal (Friend)
(Address) 402 Carrish St

15 Filed 2-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Jan 30, 1930

that I last saw h[illegible] alive on Jan 30, 1930

and that death occurred, on the date stated above, at 9 45 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Primary)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Carroll M St Clair M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL Feb 2 1930

20 UNDERTAKER Samuel I. Newsley

ADDRESS 5 N Bond

Spec.—8-16-29—L. F. S.—100 Blks.

E 53593

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 L 53593

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 E Balto ST. 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Shapos

(a) RESIDENCE NO. 624 E Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. \ mos. \ ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler 538

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Shapos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Rosa Sh (Address) 624 E Balto st

15 Filed 2-1930 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1/30

17 I HEREBY CERTIFY, That I attended deceased from Jan-26-, 1930, to Feb-1-, 1930, that I last saw alive on Feb-1-, 1930 and that death occurred, on the date stated above, at 1:15 a. m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis about 6 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

2/1/30 (Address) Herman Seidel

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workman Circle Cemet	2/2 1930
20 UNDERTAKER Sol Levinson + Bro	ADDRESS 1127 E Balto st

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53594 ✓ 90 E 53594

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1215 E. Madison ST. 10-14 WARD)

2—FULL NAME Alphonzo DE Courcy

(a) RESIDENCE NO. 1215 E Madison ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-6-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Columbus DeCourcy

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary's co Md

12 MAIDEN NAME OF MOTHER Theslene Boston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary co Md

14 Informant Howard DeCourcy

(Address) 820 N Durham

15 Filed 2-1930 C. HUNTSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 6, 1929, to Jan 31, 1930, that I last saw h alive on Jan. 30, 1930 and that death occurred, on the date stated above, at 5 30 a m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficency

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilitation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher M. D.

Jan 31 1930 (Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem.

DATE OF BURIAL Feb 2nd 1930

20 UNDERTAKER Mrs J. G. Locke

ADDRESS 1302 Jefferson St.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53595

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53595

CERTIFICATE OF DEATH

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3531 Reisterstown ST. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME IDA Lena Holodmer

(a) RESIDENCE NO. 3531 Reisterstown Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	w	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Holodmer

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER S. Mednick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dunkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant B-M Lastown

(Address) 3531 Reisterstown Rd

15 Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/2/30

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1929 to Feb 1, 1930

that I last saw h she alive on Feb 1, 1930

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Laboratory

(Signed) Walter Thomas, M. D.

Feb 4 1930 (Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 2/2 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balt St

Spec.—1-12-23—M&T—500 Blks.

E 53596

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53596

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew aged Home ST. 27-54 WARD

2-FULL NAME Annie Morgenstern (Morgenstein)

(a) RESIDENCE NO. Greenspring & Belvedere Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Morgenstern

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 72 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Sam Riel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: L. L. Caplan

(Address): 2038 Brookfield ave

15 Filed: 2-1930 19 Registrar: C. HERBERT JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan-31 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan-15-, 1930, to Jan-31-, 1930, that I last saw her alive on Jan-31-, 1930, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? urinary analysis

(Signed) Herman Sudil, M. D.

2/1/1930 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friedal

DATE OF BURIAL: 2/2 1930

20 UNDERTAKER: Jack Lewis 1439 E Balto St

ADDRESS

Please read very important "See instructions on back of certificate."

Spec.—2-29-28—L. F. S.—500 Bks.

E 53597

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53597

CERTIFICATE OF DEATH

100-00

REGISTERED NO. 13-52

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3162 Remington Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W. Stiffler

(a) RESIDENCE NO. 3162 Remington Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

.a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Aubrey M. Stiffler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ada G. Eaton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Aubrey M. Stiffler
(Address) 3162 Remington Ave.

15 Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1- 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to Feb 1st, 1930, that I last saw h[illegible] alive on Feb 1, 1930 and that death occurred, on the date stated above, at 4th a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bozzo, M. D.

. 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove, Baltimore Co.

DATE OF BURIAL Feb. 3, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc. E Leroy Stiffler & Son

ADDRESS 125 E. North Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53598

CERTIFICATE OF DEATH

E 53598

REGISTERED NO. 24

1—PLACE OF DEATH Sydenham Hospital

CITY OF BALTIMORE: (No. 14-24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Jones

(a) RESIDENCE NO. 1502 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Jones

6 DATE OF BIRTH (month, day, and year) June(?) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	41	7	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Clubhouse

(c) Name of employer Maryland Club. Richmond Va.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Moses Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliz Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Sadie Armstrong

(Address) 1026 N. Caroy St

Filed 2-1930, 19 C. H. THOMPSON JOHNS, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930 to Jan 30, 1930

that I last saw him alive on Jan 30, 1930

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Meningitis (Meningococcic)

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) None (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 1502 Division St.

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) Addison Craft Irby, M. D.

1-31, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cem. Sharp St Cem.

DATE OF BURIAL 2-2 1930

20 UNDERTAKER Byron & Wright

ADDRESS 1218 McCulloh St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53599

CERTIFICATE OF DEATH.

129 E 53599

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore General ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Jackson

(a) RESIDENCE NO. 1923 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Jackson

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Wilcox

(c) Name of employer

9 BIRTHPLACE (city or town) Essex Co (State or country) Va

PARENTS

10 NAME OF FATHER Barkey Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Bailey (Address) 1923 Aisquith St

15 Filed [illegible], 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1930 to Feb. 1, 1930, that I last saw him alive on Feb. 1, 1930 and that death occurred, on the date stated above, at 7:20 A. m

The CAUSE OF DEATH* was as follows:

Chronic Glomerular Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes (ORR) Date of Jan. 17, 1930

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) S. A. Alessi, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashury Cem

DATE OF BURIAL 2-4 1930

20 UNDERTAKER Byron W Wright

ADDRESS 1218 N Eden St

FOR A very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rls.

E 53600

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53600

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (Ward) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Angela Brogkowski

(a) RESIDENCE NO. 317 S. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 16-1929

7 AGE: Years 1 Months Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Anthony Brogkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Frances Lewandowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Frank Brogkowski 317 S. Chester St

15 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-1-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930 to Feb 1st, 1930, that I last saw her alive on Feb 1st, 1930, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH was as follows:

Cellulitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel J. Kopman, M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: Feb 3 1930

20 UNDERTAKER: John M. Weber Funeral ADDRESS: Chester

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53601

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53601

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2703 Guilford ave ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Butterfield

(a) RESIDENCE NO. 2703 Guilford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Rodolph Butterfield

6 DATE OF BIRTH (month, day, and year): June 9-1855

7 AGE: Years 74 | Months 6 | Days 21½ | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home duties

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John MacDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Prince Edward Island

12 MAIDEN NAME OF MOTHER: Mary Jane McClements

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Clement Butterfield

(Address) 2703 Guilford ave.

15 Filed 2-1-1930, 19 C. HANSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 31-30

17 I HEREBY CERTIFY, That I attended deceased from 1927, 19, to Jan 31, 19 30, that I last saw him alive on Jan 31, 19 30 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Int Nephr

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. France, M. D.

(Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

DATE OF BURIAL: 2/3/1930

20 UNDERTAKER: J. A. Inman

ADDRESS 3000 E Balto

Cor.—10-10-29—A Co.—100 Bks.

E 53602

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88

E 53602

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 700 W. Lombard St., 4-24 Ward)

2-FULL NAME Mary Hess - Hartman

(a) RESIDENCE NO. 700 W Lombard St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Factory - worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Pittsburg Plate Glass Co.

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Police Dept
(Address) Balto Md.

15 Filed 1930 Registrar C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

1/30. 1930. (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery — DATE OF BURIAL 2/31 1930

20 UNDERTAKER J. G. Moran — ADDRESS 300 E Baltas.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-29—L. F. S.—500 Blks.

E 53603

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53603

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH

REGISTERED NO. 6 10

CITY OF BALTIMORE: (No. 117 N. Milton ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Balster J. Hock.

(a) RESIDENCE NO. 117 N. Milton ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 8th 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Hock.

11 BIRTHPLACE OF FATHER (city or town) Bavaria
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Snyder

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant John T. Hock (Bro)
(Address) 117 N. Milton Ave

15 Filed 2-1 1930 C. HUMPHREY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31st 30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1930, to Jan 31, 1930, that I last saw h alive on Jan. 31, 1930 and that death occurred, on the date stated above, at 9 20 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Ichnit, M. D.

2-1-1930 (Address) 701 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb 3rd 1930

20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc	408 S. Wood St

Spec.—1-30—M. & T.—250 Bks.

E 53604

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53604

CERTIFICATE OF DEATH.

101

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 2426 E. Lee ST. 12 WARD)

2-FULL NAME John J. Wiessner

(a) RESIDENCE NO. 2426 E. Lee ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B. Wiessner

6 DATE OF BIRTH (month, day, and year) Nov 2nd 1903

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
26	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electric Truck Operator
(b) General nature of industry, business, or establishment in which employed (or employer) 073
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS
10 NAME OF FATHER Jacob Wiessner
11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)
12 MAIDEN NAME OF MOTHER Eliz Miller
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Anna B. Wiessner (Wife)
(Address) 2426 E. Lee St.

15 Filed ..... 19 ..... C. HUMPSON JONES M.D. Registrar
2-1930 By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930 to Jan. 31, 1930,
that I last saw h[illegible] alive on Jan. 31, 1930,
and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
Accidental Insufficiency
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....
(Signed) [illegible] M. D.
1/31, 1930 (Address) 2624 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.
DATE OF BURIAL Feb 3rd 1930

20 UNDERTAKER Lilly & Zeiler Inc
ADDRESS 403 S. Wolfe

Spec.—8-16-29—L. F. S.—100 Blks.

E 53605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 53605

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3312 Shelbourne Road ST. 27-5 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane Gobrecht Coleman,

(a) RESIDENCE NO. 3312 Shelbourne Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles W. Coleman,

6 DATE OF BIRTH (month, day, and year) September 15, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Jerimah W. Gobrecht.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Adams Co. Penna.

12 MAIDEN NAME OF MOTHER Rachel Stonesipher

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Carroll Co. Md.

14 Informant Miss Bessie R. Coleman
(Address) 3312 Shelbourne Road

Filed FEB 2 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JAN 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to Jan 31, 1930,
that I last saw h[illegible] alive on Jan 31, 1930
and that death occurred, on the date stated above, at 10 8 m.

The CAUSE OF DEATH* was as follows:

Cholecystitis with locking
fenitentis

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Myocarditis and Chronic Int. nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. & Lab

(Signed) Wm. E. Sittle, M. D.

2/1 1930 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Oxford Penna

DATE OF BURIAL FEB 3 1930

20 UNDERTAKER Robert S. Sittle

ADDRESS 2700 EDMONDSON AVE.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53606

CERTIFICATE OF DEATH

188-103 E 53606

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Sydenham Hosp St 27-44 (Ward)

2-FULL NAME John C Nolz

(a) RESIDENCE NO. 2906 Gordon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 3 - 1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	1	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Builder 015
(c) Name of employer Fallis

9 BIRTHPLACE (city or town) Easton Md
(State or country) Unk Known

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Elizabeth Nolz.
(Address) 2906 Gordon ave.

15 Filed ..... 19.. C. HARRISON Jones P.C. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by moving auto while crossing road Between intersection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

Central Hemorrhage - Erysipelas

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Harford Rd & Gordon Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H Braun, M. D.

2/1, 1930 (Address) 2939 W. Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Feb 4 1930

20 UNDERTAKER Geo. W. Little

ADDRESS 1701 Edmondson ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53607 ✓ E 53607

E 53607

CERTIFICATE OF DEATH.

137

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 930 E Madison St. (WARD) 10-14

2-FULL NAME Mary M. Joyce

(a) RESIDENCE NO. 930 E Madison ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Joyce

6 DATE OF BIRTH (month, day, and year) June 8. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81 yrs	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Joyce (Address) 930 E. Madison st

15 Filed 2 1930 . 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 . 1930 to Jan 31 . 1930 . that I last saw h[illegible] alive on Jan 31 . 1930 . and that death occurred, on the date stated above, at 3 1/2 p.m.

The CAUSE OF DEATH* was as follows:

Ovarian cyst-
Arteriosclerosis
Senility

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) ... yrs. ... mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Lowe, M. D.

2/1 . 1930 (Address) 1716 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Feb. 4. 1930

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 1924 E. Eager St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53608

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53608

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1919 Snyder ave ST. Dr-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Sopko

(a) RESIDENCE NO. 1919 Snyder ave. ST. Spectator Park WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of [redacted] Mary Sopko

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rail mill &c

(b) General nature of industry, business, or establishment in which employed (or employer) Sparrows point

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Michael Sopko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Mary Sopko

(Address) 1919 Snyder ave.

15 Filed 2-1930 C. HUTCHINSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-1-30

17

I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1930, to Feb 1, 1930,

that I last saw h[redacted] alive on Jan 27, 1930,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:— Cause failure

Hypertensive C. V. disease

Cardiac Hyp. & decompensation

Pulmonary Pneumonia

Chronic Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) As above

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Lab

(Signed) D. Arthur Linder, M. D.

, 19 (Address) 10 N Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart of Mary	Feb 4 1930
20 UNDERTAKER	ADDRESS
George A. Weber	705 S. Ann st

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53609

CERTIFICATE OF DEATH

90

E 53609

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Alice Harmon

(a) RESIDENCE NO. Church Home & Infirmary ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 1-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thomas Harmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Orleans La.

12 MAIDEN NAME OF MOTHER Mary Merritone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Church Home Records.

(Address)

15 Filed 2-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31, 1930

17

I HEREBY CERTIFY, That I attended deceased from January 1, 1930, to January 31, 1930, that I last saw her alive on January 31, 1930 and that death occurred, on the date stated above, at 3:25 p m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis

Unknown (duration) 1 yrs. + mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis.

(duration) 1 yrs. + mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem findings.

(Signed) W. W. Elgin, M. D.

Jan 31 1930 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Feb 3 1930
20 UNDERTAKER Stuchey Funeral Inc	ADDRESS 1st & N. Prod

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53610 | CERTIFICATE OF DEATH | 129 | E 53610

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 S. Mount ST. 19-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Hipkins

(a) RESIDENCE NO. 205 S. Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Hipkins

6 DATE OF BIRTH (month, day, and year) July 22, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Theresa M. Myles
(Address) 205 S. Mount St.

15 Filed ..... Registrar

2-1930 AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 30.

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 19 30, to Feb 2, 19 30, that I last saw h[illegible] alive on Feb 1, 19 30 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Infection of hand and forearm (left).
Cellulitis - (22 days).
Chronic interstitial nephritis.—
Myocardial insufficiency. Acute.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Ordinary examination.

(Signed) James W. Wilson, M. D.

, 19 (Address) 1120 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Feb 4. 1930.

20 UNDERTAKER H. W. Mrs. W. Teufel & Son ADDRESS 801 N. Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53611

CERTIFICATE OF DEATH

90 ✓ E 53611

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1750 E North Ave ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Jane Lynch

(a) RESIDENCE NO. 1750-E-North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 85 yrs. 4 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph S. Lynch

6 DATE OF BIRTH (month, day, and year) Sept 25 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) St Marys Co

(State or country) Maryland

PARENTS

10 NAME OF FATHER James St. Sannes

11 BIRTHPLACE OF FATHER (city or town) St Marys Co

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lunbar

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co

(State or country) Maryland

14 Informant Mrs Wm. C. Lynch daughter-in-law

(Address) 1750 E. North Ave

15 Filed 2-1930 G. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 - 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1 - 1929, to Feb 1 - 1930,

that I last saw h.e.w alive on Feb 1 - 1930

and that death occurred, on the date stated above, at 6-00 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. Gill Hall, M. D.

Feb 2, 1930 (Address) 1631 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery | DATE OF BURIAL Feb 5 1930

20 UNDERTAKER Stewart & Mason Co | ADDRESS Baltimore

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53612

CERTIFICATE OF DEATH

124 E 53612

REGISTERED NO. 15-58

1—PLACE OF DEATH
CITY OF BALTIMORE: (No.) University Hospital ST., (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa Erntstine Vogt

(a) RESIDENCE NO. 4327 Park Heights Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 60 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Vogt

6 DATE OF BIRTH (month, day, and year) October 15 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none 07
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER Ludwig Weis
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Caroline Geller
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant C. F. Vogt (Husband)
(Address) 4327 Park Heights Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/30/30

17 I HEREBY CERTIFY, That I attended deceased from 11/28, 1930, to 11/30, 1930, that I last saw her alive on 11/30, 1930 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:
Cholecystitis; Cholecystectomy

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema
Cardiac Failure (duration) yrs. mos. 4 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11/29/30

Was there an autopsy? No

What test confirmed diagnosis? Operation, Pyrexial Curve

(Signed) George Grieger M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL July 3 1930

20 UNDERTAKER Sherrard Moore & Sons ADDRESS Balto.

COMPARISON CONTD. IN

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53613

CERTIFICATE OF DEATH

74-001

E 53613

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4012 Dorchester St. 5-3-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Carroll Avad.

(a) RESIDENCE NO. 4012 Dorchester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 26 ds. How long in U. S., if foreign birth? 68 yrs. 7 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): June-6-1861

7 AGE: Years 68 | Months 7 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER: Thos. C. Carroll

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER: Mayard E. Orm

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant: Mr. Chas. L. J. Carroll Son

(Address) 4012 Dorchester Ave.

15 Filed ... 19 ... Registrar

2-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July-1-30

17 I HEREBY CERTIFY, That I attended deceased from Jan-29, 1930, to July 1-, 1930, that I last saw her alive on Jan 31, 1930 and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy, with left Side Hemiplegia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

2/1, 1930 (Address) 2202 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feb 1 19

20 UNDERTAKER: Stewart Mortuary Co. — ADDRESS: Balto.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53614

E 53614 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH Franklin Square Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 11-15 WARD)

2—FULL NAME Mr. Walter S Adams Sr.

(a) RESIDENCE NO. 208 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 6 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bell Adams

6 DATE OF BIRTH (month, day, and year) July 26 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Jacob Adams

11 BIRTHPLACE OF FATHER (city or town) Pa (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Walter Scott Adams Jr (Address) 208 E. Eager St

15 FEB 3 - 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1930

17 I HEREBY CERTIFY. That I attended deceased from Jan. 26, 1930, to Feb. 1, 1930, that I last saw him alive on Feb. 1, 1930, and that death occurred, on the date stated above, at 5.55 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure due to chronic hypertension, chronic nephritis, myocardial degeneration (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination: Hemiplegia

(Signed) M B Schreiber, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 3 1930
20 UNDERTAKER Wm J Tucker & Sons	ADDRESS North & Pa

Spec.—8-16-29—L. F. S.—100 Bks.

E 53615

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53615

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS 2569 REGISTERED NO. 90

CITY OF BALTIMORE: (No. ____ ST., ____ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Lee Slade

(a) RESIDENCE NO. 4301 Hayward Ave ST., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? — yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) March 10, 1874

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
55	10	22 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Surveyor do

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER S. L. Slade

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Adahcillah Parrish

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Md.

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed ____ 19 ____ C. HAMPSON JONES, M. D. Registrar

B 5 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-1-30

17 I HEREBY CERTIFY, That I attended deceased from 10-14, 1929, to 2-1, 1930, that I last saw h[illegible] alive on 2-1, 1930 and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) over 3 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Hypertension: Arteriosclerosis

(duration) over 3 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McLean, M. D.

2-1, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Feb. 1 1930
20 UNDERTAKER Wm. Fickus & Sons	ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—500 Blks.

E 53616 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53616

CERTIFICATE OF DEATH

101-001

REGISTERED NO. 12-50

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Mem. Hosp. ST., Randolph WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Clarence Tucker 2nd.

(a) RESIDENCE NO. Alston Apts. Chas + 33rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 8 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alice M. Tucker

6 DATE OF BIRTH (month, day, and year) May 26, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ass't Sec Treasurer

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer Safe Deposit & Trust Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Jas. R. Tucker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ida E. Hanna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. C. Clarence Tucker.

(Address) Alston Apts. Chas + 33rd

15 Filed FEB 3 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930, to Feb 1, 1930, that I last saw h.... alive on Jan 31 st, 1930 and that death occurred, on the date stated above, at 12 25 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Autopsy. Exam.

(Signed) J. H. Stafford Jr., M. D.

Feb 1, 1930 (Address) Mem. Home Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem DATE OF BURIAL Feb. 3 1930

20 UNDERTAKER Wm. J. Tucker & Sons ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—500 Blks.

E 53617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 53617

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 933 Eastern ave ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margueth Wolf.

(a) RESIDENCE NO. 933 Eastern ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) February 12 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leon. Wolf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Ann Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Wolf

(Address) 933 Eastern ave

15 Filed ..... 19 ..... Registrar

FEB 3 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 31 30

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1929 to Jan 31 1930

that I last saw h[illegible] alive on Jan 31 30

and that death occurred, on the date stated above, at 9.5A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Fred Rusby M. D.

(Address) 600 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb 3 1930.

20 UNDERTAKER Randall & Lippel — ADDRESS 301 N Eden

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53618

CERTIFICATE OF DEATH

118-802

E 53618

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1520 Thames ST. 34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony Kotowski

(a) RESIDENCE NO. 1520 Thames ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) Nov. 1. 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
		3.	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Anthony Kotowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Josephine Kuzmonski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Shellabarger Pa

14 Informant Anthony Kotowski

(Address) 1520 Thames St

15 Filed FEB 3 - 1930. C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31. 1930 to Feb 1 1930

that I last saw h[illegible] alive on Feb 1 1930

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. William Kaysen M. D.

19 (Address) 80 Rockwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Feb. 3 1930.

UNDERTAKER Wendell & Hespel.

ADDRESS 30 Aisquith

Spec.—2-29-28—L. F. S.—500 Bks.

E 53619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 200 E 53619

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1803 Linden ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Juliet R. Evans

(a) RESIDENCE NO. 1803 Linden ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 11 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 19 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mayberry Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto and

12 MAIDEN NAME OF MOTHER Mary B. Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Carrie Rodgers

(Address) 1803 Linden ave

15 Filed ..... 19 ..... Registrar

C. HERBERT JONES, M.D.

FEB 3 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930, to Feb. 1, 1930, that I last saw h alive on Feb. 1, 1930 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duratinn) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease cnntracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autnpsy? No

What test confirmed diagnosis? Usual

(Signed) Stanford McGlenny, M. D.

, 19 (Address) 1609 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Feby 3rd 1930
20 UNDERTAKER	ADDRESS
Jno B Spence	1325 N. Carlton St.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53620 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 38 E 53620

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Cornish

(a) RESIDENCE NO. 1127 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Dec 13-1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 3 - 1930 G. HUNTSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 30-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Jan 30, 1930, that I last saw h[illegible] alive on Jan 30, 1930 and that death occurred, on the date stated above, at 5 10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

Syphilitic Heart Disease

Aortic Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? PM examination

(Signed) Alexander Preston, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL Feb 3 1930

UNDERTAKER Frank E Watkins

ADDRESS 1515 N Eden St

Spec.--8-16-29—L. F. S.—100 Blks.

E 53621

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53621

90

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ST., W-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cosmo Monfort

(a) RESIDENCE NO. Mercy Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John Monfort

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Bush

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospt Record
(Address)

15 Filed ..... 19 C. HAMPSON JONES, Registrar

FEB 3 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to Feb 1, 1930,

that I last saw him alive on Feb 1, 1930

and that death occurred, on the date stated above, at 4 20 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic C. V disease

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

2/1/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monument Cem

DATE OF BURIAL 2/4/30

UNDERTAKER by A Harley Fulton

ADDRESS Baltimore

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53622

100-08

E 53622

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St. Joseph Hospital St. 5-8 (Ward)

2-FULL NAME Edward Chappell

(a) RESIDENCE NO. 1241 McElderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E Chappell Pinkie ~~Jackson~~

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer M & M S.S.Co

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Daniel Chappell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nora Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wm. Chappell
(Address) 1317 E. Madison St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31/30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
Bronchopneumonia about 7 days.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Penn, M. D.

2/3/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	2-3 1930
20 UNDERTAKER	ADDRESS
Byron Knight	1218 McElderry St

FEB 3 - 1930 C. HUNSON JONES

Important. See instructions on back of certificate.

Of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-30—M. & T.—250 Blks.

Dr Mengathroyd 401 E 25th St
Hunt 1582

E 53623

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53623

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Ramsey St. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Greer

(a) RESIDENCE NO. 1810 Ramsey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~
HUSBAND of
(or) ~~WIFE of~~ Mary E Greer

6 DATE OF BIRTH (month, day, and year) Nov 30th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 60

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Greer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN ~~Mengathroyd~~ NAME OF MOTHER Breitenbrot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christian A. Greer
(Address) 1810 Ramsey St

15 Filed 3-1930 C. Watson Jones II Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31th 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 16th, 1930, to Jan 31st 1930, that I last saw h[illegible] alive on Jan 30th, 1930, and that death occurred, on the date stated above, at 12.25 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Bronchio Pneumonia Terminal Influenza

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) [illegible], M. D.

1/31/1930 (Address) 401 E 25th St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 2/3/1930

UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53624 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53624

CERTIFICATE OF DEATH

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3553 Greenmount Ave ST. 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna E. Clifton

(a) RESIDENCE NO. 3553 Greenmount Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Harry G. Clifton

6 DATE OF BIRTH (month, day, and year) Oct 30th 1844

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Frederick Co, Md

PARENTS

10 NAME OF FATHER Lawrence Haley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Harbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Caroline E Clifton

(Address) 3553 Greenmount Ave

Filed FEB 3 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1929, to Feb 1, 1930, that I last saw her alive on Jan 31, 1930 and that death occurred, on the date stated above, at 5 — p. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S. Fruben, M. D.

2/1/30 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Tabor, Rocky Ridge, Md

DATE OF BURIAL 2/4/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53625

CERTIFICATE OF DEATH

167-001

E 53625

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Enroute

City of Baltimore: (No.) Hopkins Hospital St. 8-16 Ward)

2-FULL NAME Daniel L. Claridge

(a) RESIDENCE NO. 2522 E. Oliver St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Claridge

6 DATE OF BIRTH (month, day, and year) May 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	58	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist Helper
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer Poole & Co

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Claridge

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Herrietta Bomberger

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Elizabeth Claridge
(Address) 2522 E. Oliver St

15 Filed ..., 19.. C. [illegible] JOHNS, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31/30 1932

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Asphixiation
Suicide (Turned on gas range)

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John C. Guerin M. D.

2/1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	2/3/1930
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Exact statement of OCCUPATION is very important. See instructions on back of certificate. Certificate of death in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53626

E 53626

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 506 Cathedral St. St. 11-25 Ward)

2-FULL NAME Mattie L. Garner.

(a) RESIDENCE NO. 506 Cathedral St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced
(or) WIFE of Emmett G. Garner.

6 DATE OF BIRTH (month, day, and year) August 21, 1871.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	5	11 10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER ——— Gale.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Edwin E. Garner. (son)
(Address) 3905 Dorchester Rd.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) February 1st. 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

2/3, 1930. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Neck Gloucester Co Va	2-3-30
20 UNDERTAKER W. Cook	ADDRESS 1911 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 53627

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53627

CERTIFICATE OF DEATH. + + 65-001

1-PLACE OF DEATH Harriet Lane Hospital

CITY OF BALTIMORE: (No.) 1418 Eutaw Pl. (Street) (Ward) 14-20

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allen Edwood Leftcourt

(a) RESIDENCE No. 54th St & 5th Ave New York City WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug. 5. 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	5	24	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of Industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) U. S. a. New York

PARENTS

10 NAME OF FATHER E. E. Leftcourt

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York.

12 MAIDEN NAME OF MOTHER Emma Castelberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Johnny Castelberg
(Address) Marlborough Blvd.

15 Filed FEB 3 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7 1930, to Feb 3 1930 that I last saw him alive on Feb 3 1930, and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

Leukaemia, myelocytic acute

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

If Where was disease contracted, if not at place of death? U.S.A.

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) Edwin F. Krayer, M. D.

2/3, 1930 (Address) The Resident

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn, New York DATE OF BURIAL 2/3/1930

20 UNDERTAKER David Sondheim ADDRESS 114-20 W. 44th St. Kings Ave

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

R 85-63
E 53628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

71-00 E 53628

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 21-31 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Day

(a) RESIDENCE NO. 539 N. Wash ST. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/11/29

7 AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) NO

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Luther Day

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Brown

13 BIRTHPLACE OF MOTHER (city or town) Ga —
(State or country)

14 Informant Reads —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to Jan 31, 1930, that I last saw him alive on Jan 31, 1930, and that death occurred, on the date stated above, at 7 20 p. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) ... yrs. ... mos. 1½ ds.

CONTRIBUTORY
(Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? NO Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar Puncture and culture of blood

(Signed) R. O. Y. Thomas, M. D.

2/1, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb. 3, 1930

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 3221 Schroeder St.

FEB 3 1930 C. HAMPSON JONES, M.D.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53629

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53629

101-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 26-37

CITY OF BALTIMORE: (No. 708 S Dean ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lydia - A. Brehm

(a) RESIDENCE NO. 708 S Dean ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Brehm

6 DATE OF BIRTH (month, day, and year) June 5 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	60	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Frank Wagner

(Address) 402 S Dean Ave

15 Filed ..... 19..... J. M. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1-1930

17 I HEREBY CERTIFY, That I attended deceased from 1/31, 19 30 to 2/1, 19 30

that I last saw h[illegible] alive on 1/31, 19 30

and that death occurred, on the date stated above, at 12 30 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. 3 mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] Gaynell, M. D.

2/2/30 (Address) 633-5 Cooksing

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	Feby 4 1930
20 UNDERTAKER John Allnutt	ADDRESS 800 Baker

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53630

CERTIFICATE OF DEATH

101-001

E 53630

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 24 N. Pearl St.) (4-25 Ward)

2-FULL NAME Carl F. altl

(a) RESIDENCE NO. 24 N. Pearl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	72			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Ret'd
(c) Name of employer H. Sonnborn & Co

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Mr. John Oberleidner (Nephew)
(Address) 15 N. Delaware Ave. Atlantic City

15 Filed 2-3-1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) August Zellert M. D.

2-2-1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Feby 5 1930

20 UNDERTAKER John Meisel

ADDRESS 2008 Aliceanna

FILL in all items if possible. Be sure to write plainly, so that it may be properly examined. EXACT STATEMENT OF OCCUPATION IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53631

CERTIFICATE OF DEATH

3 2 E 53631

1—PLACE OF DEATH

REGISTERED NO. 1623

CITY OF BALTIMORE: (No. 1122 N. Lafayette St., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kermit L. Brooks

(a) RESIDENCE NO. 1122 N. Lafayette Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (Write the word): Single

6 DATE OF BIRTH (month, day, and year): Jan. 3, 1928

7 AGE: Years 2 | Months | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. City.

PARENTS

10 NAME OF FATHER: Harold E. Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Ida Broom

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Harold E. Brooks

(Address) 1122 N. Lafayette Ave

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Febr. 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 1930 to Feb. 2 1930

that I last saw h[illegible]live on Feb. 2 1930

and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia & Bronchitis about 2 Weeks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical

(Signed) John H. Youngman M.D.

19 (Address) 1012 N. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Feb. 4 1930

20 UNDERTAKER: John M. Johnson

ADDRESS 2925 Madison Ave

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53632 — E 53632

CERTIFICATE OF DEATH (Koutek)

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 702 N. Luzerne Ave ST., 7-12 WARD)

2—FULL NAME Josephine Kostek.

(a) RESIDENCE NO. 702 N. Luzerne Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Koutek.

6 DATE OF BIRTH (month, day, and year) March 20. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-Work. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia.

PARENTS

10 NAME OF FATHER Not-Known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia.

12 MAIDEN NAME OF MOTHER Not-Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia.

14 Informant Louis Koutek.
(Address) 902 N. Luzerne Ave.

15 Filed 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-3-30

17 I HEREBY CERTIFY, That I attended deceased from 1-21 19 30 to 2-3-30 19, that I last saw alive on 2-2-30 19, and that death occurred, on the date stated above, at 4:20 a. m.

The CAUSE OF DEATH* was as follows: Cancer of Stomach

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jerome Kutzmark, M. D.

2-3-30 19 (Address) 2402 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cemetery. DATE OF BURIAL: Feb. 6, 1930

20 UNDERTAKER: August Pasek ADDRESS: 2406 E. Ashland Ave.

Cor.—10-10-29—A Co.—100 Blks.

E 53633

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

V 101-901

E 53633

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5036 Oxford St. 17-2 Ward)

2-FULL NAME Leonard Harris

(a) RESIDENCE NO. 5036 Oxford. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No.

6 DATE OF BIRTH (Month, day and year): 1874

7 AGE: Years 35 Months Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Leonard Harris Sr.

11 BIRTHPLACE OF FATHER (city or town): Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER: Georgiana Harris

13 BIRTHPLACE OF MOTHER (city or town): Va.
(State or country)

14 Informant: Peggie Harris
(Address): 132 Edson St.

15 Filed: FEB 3 - 1930 H. Emerson Jones Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Jan 28th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest ..... (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) ..... M. D.

(Address) Jan 28 1930 Coroner

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 2-3 30

20 UNDERTAKER: Frank Eaton

ADDRESS 916 Park

Important. See instructions on back of certificate. Be sure to print name, as that is may be property classified. Exact statement of OCCUPATION is very

Spec.—2-29-24—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 | V. 53634

REGISTERED NO. V. 53634

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 S. Regester St. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Zygmont Lewandowski

(a) RESIDENCE NO. 509 S. Regester St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Lewandowski

6 DATE OF BIRTH (month, day, and year) Oct, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	3 4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Finisher 8 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Stanislaw Lewandowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonina Orlowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Helen Lewandowski

(Address) 509 S. Regester St.

15 Filed FEB 4 1930, 19 THOMPSON DORTS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930, to Feb 1, 1930, that I last saw h[illegible] alive on Feb. 1, 1930 and that death occurred, on the date stated above, at 3[illegible] P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Dr. Helen, M. D.

2-2, 1930 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Feb

DATE OF BURIAL 4 1930

20 UNDERTAKER F. W. Ozazewski 1930

ADDRESS Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 ✓

E 53635

CERTIFICATE OF DEATH

E 53635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 27-43 Ward)

2-FULL NAME Winifred Martin

(a) RESIDENCE NO. 5502 Pilgrim Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Martin

6 DATE OF BIRTH (month, day, and year) Feb 6/1874

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	56	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Harry Conley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kock

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mary Wills
(Address) 5502 Pilgrim Road

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over body- Clothes caught while playing with matches

Accidental (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Dementia (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/3/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkswood	Feby 1930
20 UNDERTAKER	ADDRESS
M W & Dippel Inc	37 Lan Ave

2-3-1930

IMPORTANT—Fill in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

230 E 53636 (8 48)

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 53636

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Muscella

(a) RESIDENCE NO. 411 S. High ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Muscella

6 DATE OF BIRTH (month, day, and year) Dec 9 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
31	32	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy (State or country)

PARENTS

10 NAME OF FATHER Anthony Pezza

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Rose Margaza

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 3 1930 19 HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 1929 to Jan 31 1930, that I last saw her alive on Jan 31 1930 and that death occurred, on the date stated above, at 7 40 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Subacute Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia — Anemia (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Urinalysis — Blood Chemistry

(Signed) Alexander Fenton M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 4 1930
20 UNDERTAKER	ADDRESS
Wm. E. Dapp Inc.	32 S. Arnold

Spec.—8-16-29—L. F. S.—100 Blks.

Andrew Temko ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53637

53637

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 S. Bond ST. 3-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Temko

(a) RESIDENCE NO. 832 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Temko

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER John Temko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mary Mocka

(Address) 832 S. Bond St

15 FEB 3 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Feb 1, 1930, that I last saw h[illegible] alive on Feb 1, 1930, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows: (Medical Report)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb 5 1930

20 UNDERTAKER Frank Brack Son 1906 — ADDRESS Eastlando

Cor.—10-10-29—A Co.—100 Bks.

53638

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 53638

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore (No. 902 N. Durham St., 7-13 Ward)

2-FULL NAME Joseph Hajek

(a) RESIDENCE NO. 902 N. Durham St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna Hajek

6 DATE OF BIRTH (month, day, and year) Nov 2/1885

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	44	2	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Milk Wagon Driver
(b) General nature of industry, business, or establishment in which employed (or employer) 023
(c) Name of employer Fairfield Dairy Co

9 BIRTHPLACE (city or town)
(State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Hajek

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Machacek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Anna Hajek
(Address) 902 N. Durham St

15 Filed ..., 19... Registrar

FEB 3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 31/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocarditis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..., M. D.

2/1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 4 1930
20 UNDERTAKER	ADDRESS
Frank Brack Son 1906	Oakland Cal

Be careful to print items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 ✓ E 53639

CERTIFICATE OF DEATH

E 53639

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3506 Ellerslie ST., 9-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME P. Charles Nelson

(a) RESIDENCE NO. 3506 Ellerslie ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Nelson

6 DATE OF BIRTH (month, day, and year) Aug 17 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	5	15 14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Frederick Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Barbara Ebert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Nelson

(Address) 3506 Ellerslie Ave

15 Filed 3-1930 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 19 24 to Feb 1 19 30, that I last saw him alive on Feb 1 19 30 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows: Coronary Thrombosis

(duration) 3 yrs da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs mos da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fred Rusche M.D.

1930 (Address) 800 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery

DATE OF BURIAL Feb 4 1930

20 UNDERTAKER Frank Crockett Son 1906

ADDRESS Oakland Md

Spec.—8-16-29—L. F. S.—100 Blks.

E 53640 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53640

CERTIFICATE OF DEATH

162

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2612 E. Madison ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME June Blaine Meredith

(a) RESIDENCE NO. 2612 E Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 2/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Clarence S Meredith

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Freda Garas

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Clarence Meredith
(Address) 2612 E. Madison St

15 Filed , 19 THOMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 , 1930, to Feb 2 , 1930, that I last saw her alive on Feb 1 , 1930 and that death occurred, on the date stated above, at 7:30 A.M. (7.30).

The CAUSE OF DEATH* was as follows:

Atelectasis

(Child never breathed properly & died in 2 hrs.

(duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Moran, M. D.

, 19 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill

DATE OF BURIAL Feb 3 1930

20 UNDERTAKER Hunt Brockton

ADDRESS 1906 Eldwood Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 53641 — REGISTERED NO. E 53641

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Laurens St ST. 15-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morris Blocker

(a) RESIDENCE NO. 1118 Laurens St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Bessie Blocker

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Leib Blocker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Bessie Blocker
(Address) 1118 Laurens St

15 Filed ..., 19 ... THOMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/4/30

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to Feb 2, 1930, that I last saw h... alive on Feb 2, 1930 and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency
Heart Block.
(duration) 6 mos. ds.

CONTRIBUTORY (Secondary) Hypertension
(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

. 19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Southern Ave.	2-4-1930
20 UNDERTAKER Jack Levine, 1439	ADDRESS E Baltimore St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 ✓ E 53642

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1802 Ashland ave ST., 9-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie M. Zimmermann

(a) RESIDENCE NO. 1802 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. 26 ds. How long in U. S., if foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 5 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry Zimmermann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Vogt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John Zimmermann

(Address) 1802 Ashland Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 1 - 1930

17 I HEREBY CERTIFY, That I attended deceased from October, 1929, to February 1, 1930, that I last saw h. alive on February 1 1930 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endo-myocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Ayd M. D.

Feb 3 1930 (Address) 2065 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Feb. 4 1930

20 UNDERTAKER Henry Hoeck Sons Inc.

ADDRESS 1301 E Eager St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53643

E 53643

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2301 Wichita St., (Ward) 15-58

2-FULL NAME Jacob M. Bolton (Bolton)

(a) RESIDENCE NO. 2301 Wichita St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie Witchita

6 DATE OF BIRTH (month, day, and year): Sept 1 1892

7 AGE: Years 37 | Months 6 | Days 1 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lunch Room Operator
(b) General nature of industry, business, or establishment in which employed (or employer): 680
(c) Name of employer

9 BIRTHPLACE (city or town): Russia
(State or country)

PARENTS

10 NAME OF FATHER: Baltazar

11 BIRTHPLACE OF FATHER (city or town): Russia
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town): Russia
(State or country)

14 Informant (Address): Fannie Bolton 2301 Wichita

15 Filed ....., 19.. Registrar

3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Feb 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

Apoplexy (duration) ..... yrs. Sudden

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) ..... M. D.
Feb. 13 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel

DATE OF BURIAL: 2-3- 1930

20 UNDERTAKER: Jack Levin, 1439 E Baltimore St

ADDRESS

IMPORTANT. See instructions on back of certificate. Be sure to give full name, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53644

CERTIFICATE OF DEATH

24001

E 53644

REGISTERED NO. 77-42

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 6424 Rosemont Ave ST. (WARD)

2—FULL NAME Eugenie D. Von Talbot.

(a) RESIDENCE NO. 6424 Rosemont Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. M. Talbott.

6 DATE OF BIRTH (month, day, and year): Nov. 23 1838.

7 AGE — Years: 91 — Months: 2 — Days: 8 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Wm. A. Hooper,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Englend.

12 MAIDEN NAME OF MOTHER: Jane Hooper.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Harry Talbott, (Address): 24 W. Read St.

15 Filed: FEB 3 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 31st, 1930, to Feb 1st, 1930, that I last saw h[er] alive on Feb 1st, 1930 and that death occurred, on the date stated above, at 8 50 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs + Symptoms

(Signed) Edw. A. Benson, M. D.

2/1, 1930 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount (Cem)

DATE OF BURIAL: Feby 3 1930

20 UNDERTAKER: Liston T. Funeral Home

ADDRESS: 2620 Pa Ave

Spec.—8-16-29—L. F. S.—100 Blks.

E 53645

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 53645

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 N. Bond ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Regina Long

(a) RESIDENCE NO. 1629 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 23 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Henry Long

6 DATE OF BIRTH (month, day, and year) Feb. 8, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Hugh J. Hennesey

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Ellen O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Miss Mary R. Long

(Address) 1629 N. Bond Street

FEB 3 - 1930 C. Harrison Jones, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1-1930

17 I HEREBY CERTIFY, That I attended deceased from January 26, 1930, to Feb. 1-, 1930, that I last saw her alive on January 31-, 1930 and that death occurred, on the date stated above, at 7:20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

CONTRIBUTORY (Secondary) Uncomplicated Cardiac Insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptomatic

(Signed) Benj. D. Hayden, M. D.

2/2, 1930 (Address) 1216 N. Carolina at

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 2/4 1930

20 UNDERTAKER: Henry U. Mears and Son

ADDRESS: 805 N. Calvert

Spec.—2-29-36—L. F. S.—500 Mm.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53646

CERTIFICATE OF DEATH

17-24 90

E 53646

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 549 W. Lafayette ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Alverta Powell

(a) RESIDENCE NO. 549 W. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 8 mos. 13 dys. How long in U. S., if foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

6a If married, widowed, or divorced (or) WIFE of Lewis Powell

6 DATE OF BIRTH (month, day, and year) May 20-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	59	8	13 12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Anthony Hardy

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Gould

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Lewis Powell

(Address) 549 W. Lafayette

15 Feb 1930 J. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec ___, 1929, to Feb 2, 1930

that I last saw h[illegible] alive on Feb 2, 1930

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Hemorrhoid

(duration) ___ yrs. ___ mos. 4 dys.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) ___ yrs. ___ mos. ___ dys.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ___ Date of ___

Was there an autopsy? ___

What test confirmed diagnosis? clinical

(Signed) A. K. Gamble, M. D.

, 19 (Address) 11 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Feb 5 1930

20 UNDERTAKER Wm. H. Chase Hse.

ADDRESS 1400 Madison

Cor. 10-10-29—A Co.—100 Bks.

E 53647

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 53647

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Cross St. Market. St. 23-31 Ward)

2-FULL NAME Charles C. E. Bothe.

(a) RESIDENCE NO. 4 W Clement St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 10 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of ~~WIFE of~~ Anna C. Bothe.

6 DATE OF BIRTH (month, day, and year) March 31, 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Julius F. Bothe.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Louisa Muhly.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Anna C. Bothe. (wife)
(Address) 4 W. Clement St.

15 Filed ..... 19..... Registrar

2-1-1930 C. ILLEGIBLE JONES

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 1st. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Leonhardt, M. D.

2/8, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Feb 4th 1930
20 UNDERTAKER	ADDRESS
D E Schloman & Son	Hanover Pa

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53648 ✓ 117 E 53648

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellis Bowers.

(a) RESIDENCE NO. New Windsor Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Gladys Bowers.

6 DATE OF BIRTH (month, day, and year) Oct 23. 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39 38		3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Westminster, Md.
(State or country)

PARENTS

10 NAME OF FATHER James Bowers.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Martha Hiss

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Mrs Ella Bowers
(Address) New Windsor Md.

15 Filed FEB 3 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3rd 1930.

17 I HEREBY CERTIFY, That I attended deceased from January 29th, 1930, to February 3rd, 1930, that I last saw h.m alive on February 3rd, 1930 and that death occurred, on the date stated above, at 11:15 A.m.

The CAUSE OF DEATH* was as follows:

Appendicitis Gangrenous with Peritonitis.

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? Yes Date of Jan. 28. 1930 Feb. 2. 1930.

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) Earl F. Lumbach, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Windsor

DATE OF BURIAL Feb 5 1930

20 UNDERTAKER L. H. Weimer

ADDRESS New Windsor

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53649 124 E 53649

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2014 N Charles ST., 12-51 WARD)

2—FULL NAME Martha E. McCauley

(a) RESIDENCE NO. 2014 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: L. Walty McCauley

6 DATE OF BIRTH (month, day, and year): Apr 23-1861

7 AGE: Years 68 | Months 9 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: John Stautman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Parrish

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Buckley
(Address): 241 E. Mt Washington

15 Filed: FEB 5 1930 C. S. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 2. 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930, to Feb 2, 1930, that I last saw her alive on Feb 2, 1930, and that death occurred, on the date stated above, at 10.05 a m.

The CAUSE OF DEATH* was as follows:

Acute Ordeal
Delalation
(duration) 5 yrs. mos. days

CONTRIBUTORY (Secondary) Acute Cholecystitis
(duration) yrs. mos. days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lee Richardson M. D.
Feb 4, 1930 (Address) 1 E. Mt. Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery — DATE OF BURIAL: Feb. 4 1930

20 UNDERTAKER: H. S. Marshall — ADDRESS: 359 Fall Road

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53650

CERTIFICATE OF DEATH

129

E 53650

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1834 Druid Hill Ave, Ward 70)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W Stumpf

(a) RESIDENCE NO. 1834 Druid Hill Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Stumpf

6 DATE OF BIRTH (month, day, and year) 12-26-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Theresa Ashton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Viola Allen

(Address) 1834 Druid Hill Ave

Filed 3 1930 C. ELLISON JONES, M. D. Registrar

By M R

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 27 1930, to Feb 3, 1930, that I last saw him alive on Feb 2nd, 1930 and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenzal
Hypostatic Congestion and Exhaustion

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senile Condition and age (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. F. Hall, M. D.

19 (Address) 426 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Darlington Md

DATE OF BURIAL 2-5 1930

20 UNDERTAKER George T. A. Gibson

ADDRESS 1733 Druid Hill Ave

Spec.—1-12-23—M&T—500 Blks.

E 53651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 53651

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2742 Guilford Ave., ST. 12-50 WARD)

2-FULL NAME James J. Kelly

(a) RESIDENCE NO. 2742 Guilford Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	9 10	28 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Patrick Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Catherine Dugan
(Address) 2742 Guilford Ave.,

15 Filed 2-3-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 30, 1930 to February 1, 1930, that I last saw him alive on February 1, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilitation of heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw Woodlahum, M. D.

2/3. 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Feb. 4 1930

20 UNDERTAKER: Chas F. Friend & Son

ADDRESS: 118 Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53652

CERTIFICATE OF DEATH.

129 E 53652

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1039 Brentwood Ave. (ST.) 10-15 (WARD)

2-FULL NAME Rev. Thomas E. Stapleton

(a) RESIDENCE NO. 1039 Brentwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of)

6 DATE OF BIRTH (month, day, and year) Oct. 8th. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	3 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Catholic Priest.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Stapleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Stapleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant: Mother Superior. (Address) 1039 Brentwood Ave.

15 2-3-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1st. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930. to Feb 1, 1930.

that I last saw him alive on Jan 31, 1930.

and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) mos. ds.

18 Where was disease contracted if not at place of death? (5)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) T. H. Kenny, M. D.

2/2/1930 (Address) 3755 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery.

DATE OF BURIAL: Feb. 4 1930

UNDERTAKER: Chas R. Ward & Son

ADDRESS: 118 W. Mt. Royal Ave.

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53653

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53653

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH Balto. City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 20-27 WARD)

2—FULL NAME Thomas Dunn

(a) RESIDENCE NO. 104 N. Fulton Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) 1847 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Former seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed 2-3-1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-30-30

17 I HEREBY CERTIFY, That I attended deceased from 4-23-29, 19, to 1-30-30, 19,
that I last saw him alive on 1-30-30, 19
and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

1-30 19 30 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL VERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS FEB 3 - 1930

Commissioner Health

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 181-001

E 53654

E 53654

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 515 N. Brice St. 20-69 Ward)

2-FULL NAME Patrick H. Witzler

(a) RESIDENCE NO. 515 N. Brice St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no.

6 DATE OF BIRTH (month, day, and year) July 4-1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	32	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Helper B. R. R.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Henry J. Witzler

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Mary E. Weil.

13 BIRTHPLACE OF MOTHER (city or town) Balto md
(State or country)

14 Informant Florence Hartman
(Address) 540 N. Brice

15 Filed ....., 19.... Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows

Accident

Asphyxia

(duration) Sudden

CONTRIBUTORY (Secondary) Illuminating Gas

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Inquest

(Signed) H. B. Leach, M. D.

Feb 3rd (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park.

DATE OF BURIAL Feb. 4-1930.

20 UNDERTAKER Charles J. Schwab.

ADDRESS 505 N. Monroe St.

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53655

1811 E 53655

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 515 Brice St., 20-69 Ward)

2-FULL NAME Mary C. Witzler

(a) RESIDENCE NO. 515 Brice St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry F.

6 DATE OF BIRTH (month, day, and year) July 10-1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	69	6	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Florence Hartman
(Address) 540 Brice

15 Filed ..... 19 ..... C. P. JAMESON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident

Asphyxia

Sudden (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY Illuminating Gas
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Abel Hunt, M. D.

Feb 2 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Feb. 4. 1930.
20 UNDERTAKER	ADDRESS
Charles J. Schwab	545 N. Monroe St.

important. See instructions on back of certificate.

FEB 3 - 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53656

CERTIFICATE OF DEATH

181-001 E 53656

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 515 N. Bruce St., (20-69 Ward)

2-FULL NAME Henry J. Witzler

(a) RESIDENCE NO. 515 N. Bruce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary C.

6 DATE OF BIRTH (month, day, and year) Dec 19 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	68	1	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired R. R. Employ.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Witzler

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Rukenbrun

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Florence Hartman
(Address) 540 N. Bruce

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH was as follows:

Hemiplegia

(duration) Sudden mos.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. B. Hirsh, M. D.

Feb 3rd 1930 (Address) Bruce

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL Feb. 4.- 1930.

20 UNDERTAKER Charles J. Schwab. ADDRESS 545 N. Monroe St.

B 1930

Important. See instructions on back of certificate. Be exact in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-12-23—M&T—500 Bks.

E 53657 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53657

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1311 Mt. Royal Ave ST. 11-24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Winters

(a) RESIDENCE NO. 1311 Mt Royal Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 19th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	9	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Frank H Winter

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary A. Sharpley

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Miss Mae Schaub
(Address) 1311 Mt Royal ave

15 Filed 4-7 1930 C. HANSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/3 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/3, 1930, to 2/3, 1930, that I last saw her alive on 2/3, 1930, and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 2/6/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

Spec.—1-30—M. & T.—250 Blks.

D. Keown 1938 Linden Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53658

E 53658

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 307 Robert St ST. 14-20 WARD)

2-FULL NAME Martha E. Tyler Shorey

(a) RESIDENCE NO. 307 Robert St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND~~ of
(or) WIFE of Nehemiah B. Shorey

6 DATE OF BIRTH (month, day, and year) June 20th 1844

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
85	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Daniel M. Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ann Bancroft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Miss Mabel Shorey
(Address) 307 Robert St

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1930, to Feb 2, 1930, that I last saw h[illegible] alive on Feb 1, 1930, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis - Senility

(duration) 95 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) D. O. Keown, M. D.

2/3, 1930 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 2/4/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

FEB 4 1930

Spec.—1-30—M. & T.—250 Bks.

3705 Liberty Hgts

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53659

E 53659

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3814 Gwynn Oak Ave (St.) 28-64 (WARD)

2-FULL NAME Henry C Battenberg

(a) RESIDENCE No. 3814 Gwynn Oak Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Gertrude H.

6 DATE OF BIRTH (month, day, and year) July 28—1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48	58	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm Battenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Lippe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gertrude H Battenberg (Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-2-30

17 I HEREBY CERTIFY, That I attended deceased from 1-29-, 1930, to 2-2-, 1930 that I last saw him alive on 2-2-, 1930 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Americus Sorell M.D.

2/3/ 1930 (Address) 3705 Liberty Hgts Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL 2/5 1930

20 UNDERTAKER Milham Corse

ADDRESS 1217 W Pratt St

Spec.—1-30—M. & T.—250 Blks.

Dr Signed 1315 N Chas St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53660 E 53660

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 2135 N Smallwood ST. 15-60 (WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Sheirich

(a) RESIDENCE NO. 2135 N Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Sheirich

6 DATE OF BIRTH (month, day, and year): Oct 27, 1854

7 AGE — Years: 75 — Months: 3 — Days: 7 6 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter Retired 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Emanuel Sheirich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Katherine Manchey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Wm R Sheirich (Address) 2135 N Smallwood St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 3. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 8, 1930, that I last saw him alive on Feb 1, 1930, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Blood Pressure S 250 D 100
Pulse 30-36 very Weak
Heart failure
Ang (duration) yrs. 6 mos ds.
CONTRIBUTORY (Secondary) arteriosclerosis
(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Over period yrs Home

Did an operation precede death? Leg Date of Amputation

Was there an autopsy? No Two yrs ago

What test confirmed diagnosis? Very Sudden death

(Signed) P. S. Bourdeau-Esco M. D.

19 (Address) 1315 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: United Brethren Cemetery Manchester Md

DATE OF BURIAL: 2/6/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 E Fayette St

Spec.—2-29-28—L. F. S.—500 Bks.

E 53661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 V

E 53661

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 Myrtle Ave) (WARD)

2—FULL NAME Alice C. Haynes

(a) RESIDENCE NO. 1104 Myrtle Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Anthony Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nash —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant John Craig

(Address) 1104 Myrtle

15 Filed 1930, 19 C. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/1/30

17 I HEREBY CERTIFY, That I attended deceased from 1/4, 1930, to 2/1, 1930, that I last saw her alive on 2/1, 1930 and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Interstitial Nephritis (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Probably (Senility) (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical, microscopical

(Signed) J. Jno. Bowles, M. D.

2/3/30 (Address) 908 S Shore Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Feb 4 1930
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Druid Hill

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53662

CERTIFICATE OF DEATH

E 53662

REGISTERED NO. 51 E 53662

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Edmondson St. 6-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Price

(a) RESIDENCE NO. 1004 Edmondson St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson Price

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md

PARENTS

10 NAME OF FATHER Thos Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katie Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nelson Price

(Address) 1004 Edmondson Ave

15 Filed ____, 19____ C. HERBERT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 30

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1930, to July 1, 1930

that I last saw her alive on January 01, 1930

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) David Gladmon M. D.

7-1, 1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisonville Cem

DATE OF BURIAL 7/4 1930

20 UNDERTAKER Emmert Hemsley

ADDRESS 578

Spec.—8-16-29—L. F. S.—100 Bks.

E 53663 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 53663

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1125 Fronton ST. 10-14 WARD)

2—FULL NAME Lucia Franco

(a) RESIDENCE NO. 1125 Fronton St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/29/1929

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
-	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Mariano Franco.

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Louie Franco.

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Mariano Franco.
(Address) 1125 Fronton St

15 Filed 2-4 1930. 19 Per C. HARPER JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to Feb 3, 1930, that I last saw h alive on Feb 2, 1930 and that death occurred, on the date stated above, at 9 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm I Kittredge M. D.

2-3. 1930 (Address) 1038 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 2/4/30. 19

20 UNDERTAKER George J Ruth Sons

ADDRESS 1535 Hanford

Spec.—8-16-29—L. F. S.—100 Bks.

E 53664

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53664

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N Gilmor St (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie A Jackson

(a) RESIDENCE NO. 217 N Gilmor St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo Jackson

6 DATE OF BIRTH (month, day and year): Jan 13 1877

7 AGE: Years 53 | Months 0 | Days 13 | If LESS than 1 day, hrs. or min. 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Nancy Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Amelia Sanders

(Address) 217 N Gilmor St

15 Filed 1930 C. Hampton Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 2nd. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 1930 to Feb. 2 1930, that I last saw her alive on Feb. 1st. 1930 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Brooken Cardiac Compensation

Mitral Ins/.

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Ch. Inter. Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn DATE OF BURIAL: Feb 5 1930

20 UNDERTAKER: Thomas E Wyatt ADDRESS 1364 Hanover

Spec.—8-16-29—L. F. S.—100 Bks.

E 53665 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 101-001 E 53665

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 13-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Solomon Levy

(a) RESIDENCE NO. 2126 Bolton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	27	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Palestine

PARENTS

10 NAME OF FATHER Fishel Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Palestine

12 MAIDEN NAME OF MOTHER Lillian —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Palestine

14 Informant S. Margoles

(Address) 1737-E. Balto St

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1930, 19..., to Feb. 3, 19 30.,

that I last saw h[illegible] alive on Feb. 3, 19 30

and that death occurred, on the date stated above, at 1 45 P. m.

The CAUSE OF DEATH* was as follows:

(Pneumonia) Bronchopneumonia —

Pneumococcus Type I Gram Negative Rod

(duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteria Typing - Mouse inoculation

(Signed) Leroy P. Leach, M. D.

2-3, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mount Road

DATE OF BURIAL 2/4 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto St

Spec.—2-29-28—L. F. 3.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53666

CERTIFICATE OF DEATH

31 E 53666

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1632 N. Wolfe ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Schmidt

(a) RESIDENCE NO. 1632 N. Wolfe ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Elij Schmidt

6 DATE OF BIRTH (month, day, and year) Nov. 12th 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
63	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter. 1/2

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Susanna Willbur

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Joseph H. Kuhn.
(Address) 1632 N. Wolfe St.

15 Filed 4 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1930, to Feb 2, 1930, that I last saw h[illegible] alive on Feb 2 1930, and that death occurred, on the date stated above, at 2 40 P. m.

The CAUSE OF DEATH* was as follows:

Pul. TB.

C & L Lawshow (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sp. Ex.

(Signed) G. C Bladen, M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Lutha Cemetery	Feb 5th 1930
20 UNDERTAKER Lilly & Zeiler Inc.	ADDRESS 403 S. Wolfe St

Spec.—3-24-14—M. & T.—2000 Blm.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53667 — 90 E 53667

CERTIFICATE OF DEATH.

REGISTERED NO. C .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2612 Talbot Rd) (Ward 15 16)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomley D. Harris

(Residence in Baltimore: No. 2612 Talbot Road St.; 10 yrs., ~ mos. ~ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): widower

6-DATE OF BIRTH: Feb (Month) 10 (Day), 1857 (Year)

7-AGE: 72 yrs. 11 mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Merchant Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): South Carolina

PARENTS.

10-NAME OF FATHER: Wm. C. Harris

11-BIRTHPLACE OF FATHER (State or Country): South Carolina

12-MAIDEN NAME OF MOTHER: Mary J. Schmale

13-BIRTHPLACE OF MOTHER (State or Country): South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gertrude Bankhard

(Address) 2612 Talbot Road

15- Filed Feb 4 1930 — C. HAMPSON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 3 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 28 1930, to Feb 3 1930, that I saw h[illegible] alive on Feb 2 1930, and that death occurred, on the date stated above, at 8 AM m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ....yrs. ....mos. 6 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(Duration) ?yrs. ....mos. ....ds.

(Signed) Walter Dunbight M. D.

Feb 3/30, 191... (Address) 2220 Harrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Greenville S. Car. — DATE OF BURIAL: Feb 4, 1930

20-UNDERTAKER: Jos Jacobs Son — ADDRESS: 217 S. Pa

Spec.—8-16-29—L. F. S.—100 Bks.

E 53668

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 53668

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 10

CITY OF BALTIMORE: (No. 5029 N. Patterson Park Ave ST., 10th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara Weber

(a) RESIDENCE NO. 5029 N Patterson Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Louis R. Weber

6 DATE OF BIRTH (month, day, and year) May 29-1896

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
33	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John F. Bates

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Seitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Bates (Address) 5029 N. Patterson Park Ave

15 Filed 1-30-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-2-30

17 I HEREBY CERTIFY, That I attended deceased from 1-28, 1930, to 2-2, 1930, that I last saw h alive on 2-2, 1930 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Diffused.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) P. I. B.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical + fluoroscopic

(Signed) S Duncan M. D.

2-3, 1930 (Address) Medical arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Feb 6 1930

UNDERTAKER Wm E. Miller & Son 1334

ADDRESS Jefferson St

34-1930

Spec.—6-9-19—H. P. Co.—1000 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53669 — 44E 53669

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 E Madison St. 9-12 WARD)

2-FULL NAME Frank H. Burton

(a) RESIDENCE No 2400 E. Madison ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Burton

6 DATE OF BIRTH (month, day, and year) Sept 23 - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Park Police

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William F. Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Schink

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Matilda Burton (Address) 2400 E. Madison St.

15 [illegible] (Relative)

FEB 4 - 1930 C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 1930, to Feb. 2 1930, that I last saw h[illegible] alive on Feb. 1st 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure with Pulmonary Edema (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) W. H. Bupert, M. D.

19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cemetery	Feb 5th 1930
20 UNDERTAKER	ADDRESS
Chas E. Miller & Son	2334 Jefferson

FILL IN very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53670

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53670

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 S Conklin ST. 16-13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E. Williams

(a) RESIDENCE NO. 1000 S. Conklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hecta David Williams

6 DATE OF BIRTH (month, day, and year) Nov 28-1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry Fritz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Kippe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Bertha Stuhr.

(Address) 3112 Kentucky Ave

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2 1930

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1930, to February 2, 1930, that I last saw her alive on February 2, 1930 and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb N Athey, M. D.

Feby 3, 1930 (Address) 100 S Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL Feb 6 1930

UNDERTAKER Jas E. Miller & Son

ADDRESS 2334 Eastern Ave

84 - 1930

G. HAMILTON JONES, M.D.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53671

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53671

CERTIFICATE OF DEATH

100-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 N. Montford Ave ward 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas J. Roddy

(a) RESIDENCE NO. 401 N Montford Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Roddy

6 DATE OF BIRTH (month, day, and year) Oct 1-1879.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Thomas J. Roddy

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Bridget Fennon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Theresa Roddy

(Address) 401 N Montford Ave

15 Filed Feb 4 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1930, to Feb 1, 1930, that I last saw him alive on Feb 1, 1930 and that death occurred, on the date stated above, at 1145 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Standiford, M. D.

2/3, 1930 (Address) 216 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL Feb 5 1930

20 UNDERTAKER Mrs C. Miller & Son

ADDRESS 2831 Gay

Spec.—2-19-28—L. F. S.—500 Bks.

E 53672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓ E 53672

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2428 E Madison ST., (or) 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Gale Chamberlain

(a) RESIDENCE NO. 2428 E Madison ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced (or) WIFE of: Richard G Chamberlain

6 DATE OF BIRTH (month, day, and year): May 7/1860

7 AGE: Years 69; Months 8; Days 25; If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jno R Crozier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Koehlepp

(Address) 2428 E. Madison St

15 Filed FEB 4 1930 H. LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 2-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929 to Feb 2, 1930, that I last saw h[illegible]ive on Feb 1, 1930 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Intestine

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Toxic absorption

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Coon, M. D.

2/3, 1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Feb 5 1930

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St

Cor.—10-10-29—A Co.—100 Bks.

E 53673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1930 E 53673

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Home St., 1-2 Ward)

2-FULL NAME Laura M. Reynolds

(a) RESIDENCE NO. 525 S. Linwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 9/1911

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	18	5	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Cork & Seal Co
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Clarence B. Reynolds

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Dora M. Riley

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Clarence B. Reynolds
(Address) 525 S. Linwood Ave

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to her death (autopsy or inquiry)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Lighting Fire with Coal oil

Burns. 2nd & 3rd Degree.

(duration) yrs. mos. 6 Hrs

CONTRIBUTORY (Secondary) Shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) G C Wade M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fallston Md.

DATE OF BURIAL Feb 4 1930

20 UNDERTAKER Philip Sterling

ADDRESS 2016 Orleans St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53674

CERTIFICATE OF DEATH

90 E 53674

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2707 Ashland Ave. WARD) 7-12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anton F. Svec

(a) RESIDENCE NO. 2707 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Tillie Svec

6 DATE OF BIRTH (month, day, and year) July 1 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Cutter 880

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank Svec

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Barbara - 2

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Tillie Svec

(Address) 2707 Ashland Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1930 to Feb 3 1930

that I last saw h alive on Feb 3 1930

and that death occurred, on the date stated above, at 6 04 m.

The CAUSE OF DEATH was as follows*: Mitral Regurgitation

(duration) yrs. mos. dys.

CONTRIBUTORY (Secondary) Arteriosclerosis Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Weatherbee Hay M.D.

19 36 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Feb 6 1930

20 UNDERTAKER Philip Henig

ADDRESS 2016 Orleans St

Stock—12-23-21—E.B.R.S.—400 Sks.

E 53675 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 101-601 E 53675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 42 E. Heath St., 2nd Ward) Registered No. 34

2-FULL NAME... Hubert J. Blakeley

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 42 E. Heath St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White.

5-Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 29 [illegible]

7-AGE. 23 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Pipefitter
(b) General nature of industry, business, or establishment in which employed (or employer): 059
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Frank. Blakeley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md.

12-MAIDEN NAME OF MOTHER, Margaret Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-Informant (Husband) Father Frank Blakeley
(Address) 42 E. Heath St

15-Filed [illegible] 1930 HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 3-30

17-I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930 to Feb 3, 1930

that I last saw h[illegible] alive on Feb 2, 1930

and that death occurred, on the date stated above, at 2-05 A.m.

The CAUSE OF DEATH* was as follows:

Labor Premature

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Edocarditis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. L. Campbell M. D.

2/3, 1930 (Address) 1640 Hanover

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cemetery — DATE OF BURIAL. Feb 5th 1930

20-UNDERTAKER. Fred A. Wenck & Son. — ADDRESS 703 S. Hanover St.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53676

CERTIFICATE OF DEATH.

101-001

E 53676

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3208 N Calvert St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard N Smith

(a) Residence No. 3208 N Calvert St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced, (Write the word.): M

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Della E. Smith

6-DATE OF BIRTH (month, day and year): Sept 29 87

7-AGE: 42 yrs. 3 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Lithographer

(b) General nature of industry, business, or establishment in which employed (or employer): American Can Co

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Charles H Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Mary Murphy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ohio

11- (Informant) Mrs Della E Smith

(Address) 3208 N Calvert St

15- Filed Feb 4 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 2 30

17- I HEREBY CERTIFY, That I attended deceased from Dec. 28th 1929 to Feb. 2nd 1930 that I last saw h. alive on Feb. 2nd 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George G. Cross M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Interring Pine Grove Md

DATE OF BURIAL: Feb 4, 1930

20-UNDERTAKER: W M Coulson

ADDRESS 223 S Paca St

4 = 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53677

CERTIFICATE OF DEATH

× 90 ✓ E 53677

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME Antonios Zartaloudis

(a) RESIDENCE NO. Sparrows Point Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: Years 41 | Months | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Book-keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Greece

PARENTS

10 NAME OF FATHER Sotirios Zartaloudis

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Greece

12 MAIDEN NAME OF MOTHER Maria Ferbus

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Greece

14 Informant: Eleanor Solomon
(Address): Edgemere Md

Filed 4 1930 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

2-3. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Feb 4 1930

20 UNDERTAKER: John F. Denny

ADDRESS: [illegible]

Be sure to print legibly, so that it may be properly classified. Enter statement of OCCUPATION LAST important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53678

CERTIFICATE OF DEATH

4-182 E 53678

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Pier No. 5 Pratt St. St., 4-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Oscar Barkley.

(a) RESIDENCE NO. Cambridge, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of Laura Barkley

6 DATE OF BIRTH (month, day, and year) November 14, 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	2	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mariner.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co. Md
(State or country)

PARENTS

10 NAME OF FATHER William T. Barkley.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dorchester Co. Md

12 MAIDEN NAME OF MOTHER Amanda Ruark.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dorchester Co. Md

14 Informant Thomas Barkley. (brother)
(Address) Cambridge Md.

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 2nd. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a wharf.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & inquiry

(Signed) Chas. McC. Steinhardt M. D.

2/4 1930 (Address) 1017 N. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge, Md.

DATE OF BURIAL Feb. 4 1930

20 UNDERTAKER John F. Leonard

ADDRESS 715 Light St

Important. See instructions on back of certificate.

2-4-1930

Spec.—1-10-21—M&T—1500 Bks.

E 53679

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53679

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. 15-58

CITY OF BALTIMORE: (No. ..... S. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Rose

(a) RESIDENCE NO. 3813 Reisterstown Rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred lifetime How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norton L. Rose

6 DATE OF BIRTH (month, day, and year) Aug. 28, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Eli Elsader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Einstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Clifton Rose (Address) 3813 Reisterstown Rd.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1930

17

I HEREBY CERTIFY, That I attended deceased from 1-31, 1930, to 2-3, 1930,

that I last saw h[illegible] alive on 2-3 1930,

and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Myocardial failure.

Chr. myocarditis

Aortic stenosis & insufficiency

Mitral stenosis & insufficiency (duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chr. rheumatic heart disease (duration) 20 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) B. Cohen M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 2/5/1930

20 UNDERTAKER David Sondheim

ADDRESS 1510 W. Mt. Royal Ave

THOMPSON JOINTS. LTD.

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53680

CERTIFICATE OF DEATH

74901 ✓

E 53680

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital, St. 14-20 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie Getz.

(a) RESIDENCE NO. 1701 Linden Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	60	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Getz.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Rose Steigerwald.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant L. Steigerwald.
(Address) 1701 Linden Ave.

15 Filed ..., 19... [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1701 Linden Ave. Jany. 28. 1930
No.
Did an operation precede death? Date of
Was there an autopsy? Autopsy & inquiry
What test confirmed diagnosis? Autopsy & inquiry

(Signed) Otto M. Finnegan, M. D.

2/4, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew

DATE OF BURIAL 19

20 UNDERTAKER David Sondheim

ADDRESS 1120 W. Pratt

Important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 53681

1—PLACE OF DEATH Baltimore City Hospitals (The) REGISTERED NO.

CITY OF BALTIMORE: (No. 20-21 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Smith

(a) RESIDENCE NO. 202 Appleton st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
23	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress 670

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed 2-4-1930 C. Hampton Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 7, 1929, to Feb. 1, 1930, that I last saw her alive on Feb. 1, 1930 and that death occurred, on the date stated above, at 7.05. p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. Shrader Jr. M. D.

2-3-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Quinton V.a

DATE OF BURIAL Feb 4 1930

20 UNDERTAKER Edward Bryan

ADDRESS 163 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

E 53682

HEALTH DEPARTMENT—CITY OF BALTIMORE

53682

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST., 20-70 (WARD)

2-FULL NAME Joseph Mazzetti

(a) RESIDENCE NO. 321 Allamont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 50 mos. ds. How long in U. S., if of foreign birth? yrs. 50 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa Mazzotte

6 DATE OF BIRTH (month, day, and year): 3 March 1859

7 AGE — Years: 70 — Months: 10 — Days: 29 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Domenick Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Charles Imbaterra
(Address) 123 S. Fulton St

15 Filed 4-1930, 19 ..... WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-2 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-27, 1930, to 2-2, 1930, that I last saw h alive on 2-2, 1930, and that death occurred, on the date stated above, at 1015 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Nephritis
(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Laboratory + Clinical

(Signed) S. Robert Laudo, M. D.

, 19 (Address) St Joseph's Hospital 3105 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Cathedral — DATE OF BURIAL: Feb 5 1930

20 UNDERTAKER: Frank V. Pipitone — ADDRESS: 251 E. Baltimore

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53683

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53683

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital. REGISTERED NO. 45

CITY OF BALTIMORE: (No. 8-17 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Minnick

(a) RESIDENCE NO 1902 E. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married -

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of John F. Minnick

6 DATE OF BIRTH (month, day, and year) July 17th 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) W. Va (State or country)

PARENTS

10 NAME OF FATHER Thos. Blair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Katherine Harley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Nellie Kennedy

(Address) 1902 E. Lafayette Ave.

15 Filed 2-4-1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-3-30

17 I HEREBY CERTIFY, That I attended deceased from 11-29 1929 to 2-3 1930, that I last saw h[illegible] alive on 2-3 1930 and that death occurred, on the date stated above, at 9.50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(duration) 1 yrs. mos. da

CONTRIBUTORY (Secondary) Arteriosclerosis ev Senes

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) J Leyko, M. D.

2/3 1930 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Long Green, Balto. Co. Md.

DATE OF BURIAL 2/6 1930

20 UNDERTAKER E. D. Fanning, Inc. ADDRESS 1982 E. Lafayette Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53684 ✓ E 53684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO. 7-13

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 E Monument ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sadie Robinson

(a) RESIDENCE NO. 1618 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co
(State or country) md

PARENTS

10 NAME OF FATHER Henry Robinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Estella Fennell

(Address) 1618 E Monument

15 B 4 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1929, to Feb 2, 1930, that I last saw h alive on Jan 1 1930 and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular heart disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Edward Fisher, M. D.

2-2 1930 (Address) 1618 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Lawn

DATE OF BURIAL Feb 5 1930

20 UNDERTAKER Robt E Williams

ADDRESS Wilkens Ave & Gilmor

Spec.—2-29-28—L. F. S.—500 Blks.

Worth 27

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53685

CERTIFICATE OF DEATH

E 53685

REGISTERED NO. 111-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 4 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ludwig Chalmocki

(a) RESIDENCE NO. Pratt & Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~mos.~~ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51	~~57~~			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker 084

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Chalmocki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Bettie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record

(Address)

15 Filed B4 - 1930 19 G. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-2-30

17 I HEREBY CERTIFY, That I attended deceased from 12-16, 1929, to 2-2, 1930, that I last saw him alive on 2-2, 1930 and that death occurred, on the date stated above, at 7 50 P. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. 3 days

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 1-28-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Ellis Hampshire, M. D.

2-3, 1930 (Address) Balt City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Hannans Cemetery — DATE OF BURIAL: Feb 5 1930

20 UNDERTAKER: George A. Weber — ADDRESS: 705 Lamont

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 53686 — 101-09 — D 53686

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2128 Mo Holly ST. 15-6 (WARD)

2-FULL NAME Mrs. Margaret J. Rehberg

(a) RESIDENCE NO. 2128 Mo. Holly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Henry A Rehberg

6 DATE OF BIRTH (month, day, and year) Oct 10, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	61	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 37

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Annes Co Md

PARENTS

10 NAME OF FATHER William S Copeland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Prudence Story

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Henry A Rehberg (Address) 2128 Mo Holly Ave

15 Filed 4-1930, 19 ... H. WALTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb - 3 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930, to Feb 3 —, 1930, that I last saw h~~er~~ alive on Feb 3 —, 1930, and that death occurred, on the date stated above, at 11-15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. Gill Hall M. D.

Feb 3 1930 (Address) 1631 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Feb 5 1930

20 UNDERTAKER George J Smith — ADDRESS 1532 Hollins

'TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53687

CERTIFICATE OF DEATH

E 53687

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 N. Calvert ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew G. Schmidt

(a) RESIDENCE NO. 903 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Yrs. Lifetime Mos. How long in U. S., If foreign birth? Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine Schmidt

6 DATE OF BIRTH (month, day, and year): Sunday 2nd 1878

7 AGE: Years 51 | Months 7 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John N. Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Elizabeth Boucher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Katherine Schmidt (Address) 903 N. Calvert St.

15 Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 2-30

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1926, to Feb 2, 1930, that I last saw him alive on Feb 2, 1930 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Rectum

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 1926

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M. D.

2/3, 1930 (Address) 9855 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Feb 5 1930

20 UNDERTAKER: Chas. H. Ward & Son — ADDRESS: 1180 W. Royal Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53688

CERTIFICATE OF DEATH

17 E 53688

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2810 Oak St. 12-51 (Ward)

2-FULL NAME Noah D Walker

(a) RESIDENCE NO. 2810 Oak St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marguerite E. Ahern

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bond Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer National City Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry M. Walker

11 BIRTHPLACE OF FATHER (city or town) Balto. Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice T. McMahon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Henry M. Walker
(Address) 2927 N. Calvert Street

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

Upon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide
Gun Shot of Head
Person
(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Stock
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What tests confirmed diagnosis? Inquiry

Feb 30 1930

(Signed) C. Glades, M. D.

(Address) 4330 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	2/5 1930

20 UNDERTAKER Hendrey U. Mears & Son ADDRESS 805 N. Calvert

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

4

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53689

CERTIFICATE OF DEATH

25-001 E 53689

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane Padgett

(a) RESIDENCE NO. Preston + Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	77	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER J. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Jane Schaberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston + Valley St

15 FILED 4-1930 C. E. AMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1926, to Feb 3, 1930

that I last saw h alive on Feb , 1930

and that death occurred, on the date stated above, at 3 30 p. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Leonard Wood M. D.

2/4. 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cathedral

DATE OF BURIAL Feb 5 1930

20 UNDERTAKER Rita Weidefeld

ADDRESS 2114 Greenmount Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓

E 5.3590 E 5.3590

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1423 E Fayette ST. 5-8 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hazel Davis

(a) RESIDENCE NO. 1423 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4/1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work Odo

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Davis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Wilson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Annapolis Md

14 Informant Mrs Emma Davis (mother)
(Address) 1423 E. Fayette St

15 Filed 4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1/1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 24, 1929, to Feb 1, 1930,

that I last saw h alive on Feb 1, 1930

and that death ocrurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) B Davis M. D.

2/4, 1930 (Address) 390 Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Evergreen Cemetery	2/5/ 1930
20 UNDERTAKER	ADDRESS
Mrs & Chas G. Bailey	1421 Jefferson St

Spec.-7-17-26—A Co.—200 Bks.

53691

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 117 E 53691

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

City of BALTIMORE: (No. 1 Howard & Madison St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Eyler

(a) RESIDENCE NO. Reisterstown, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles B Eyler

6 DATE OF BIRTH (month, day, and year): Oct 19, 1875

7 AGE — Years: 54 — Months: 3 — Days: 15

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town): Carroll Co

(State or country): Md

PARENTS

10 NAME OF FATHER: John W Gant

11 BIRTHPLACE OF FATHER (City or town): Frederick Co

(State or country): Md

12 MAIDEN NAME OF MOTHER: Hannah Miller

13 BIRTHPLACE OF MOTHER (city or town): Frederick Co.

(State or country): Md

14 Informant: Hosp Records

(Address)

15 Filed 4-1930 C. HALPSON JONES, M. D.

Reg. Dar ADD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1930, to Feb 4, 1930, that I last saw her alive on Feb 4, 1930, and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis Hemorrhagic

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) ..... yrs. ..... mos. 11 ds.

18 Where was disease contracted

If not at place of death? -

Did an operation precede death? Yes Date of Jan 24

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) H. K. Mosher, M. D.

Feb 4, 1930 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hawkes Cemetery

Date of Burial: Feb 7 1930

20 UNDERTAKER: H M Routson

ADDRESS 223 E North

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53692

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53692

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 17-24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Patterson

(a) RESIDENCE NO. 544 Camel St., N.W. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
43	44	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hauling

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER John McHenry

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Manda Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ..., 19.. ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-31-30

17 I HEREBY CERTIFY, That I attended deceased from 12-24-29, 19.., to 1-31-30, 19..,

that I last saw him alive on 1-31-30, 19..

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

~~1a.~~ Tuberculosis of Lungs & Intestine

(duration) ... yrs. 6? mos. ... ds.

CONTRIBUTORY (Secondary) Tuberculosis of Peritoneum

(duration) 1 yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvey M. McLean, M. D.

2-1, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

C. HANSON JONES, M. D.

Commissioner of Health

FEB 4 - 1930

1 - 1930 4525

Per [illegible]

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53693 E 53693

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 15-25 ST. WARD)

2—FULL NAME Mary Oaks

(a) RESIDENCE NO. 1313 N. Monroe St. ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N.C.

PARENTS

10 NAME OF FATHER: Daniel Palmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant: Records of
(Address) Balto. City Hosp.

15 FEB 4 - 1930 19 C. HAMPSON JONES, M. D. Registrar

4-1930 4526

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-29-30

17 I HEREBY CERTIFY, That I attended deceased from 1-19-30, 19..., to 1-29-30, 19..., that I last saw her alive on 1-29-30, 19..., and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency; Hypertension over 11 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

1-30, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

FEB 4 - 1930

Commissioner Health

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53694

E 53694

CERTIFICATE OF DEATH

REGISTERED NO. 31

1—PLACE OF DEATH Baltimore City Hospitals (5b-8 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2—FULL NAME Zean DeCoursey

(a) RESIDENCE NO. 380 Forrest st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 0-40

(b) General nature of industry, business, or establishment in which employed (ar employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Zean DeCoursey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address) UN

15 Filed 4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1928, to Jan. 29, 1930, that I last saw him alive on Jan. 29, 1930 and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Tuberculous meningitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

1-29, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, ar in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, ar Hamicidal. (See reverse side far additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
VERSITY OF MARYLAND	19
20 UNDERTAKER Commissioner Health	ADDRESS FEB 4 - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

Rozanowski ✓

E 53695 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53695

90

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 S Dallas St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Rozanowski

(a) RESIDENCE NO. 803 S Dallas St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Rozanowski

6 DATE OF BIRTH (month, day, and year) April 10 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62 63	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ? Kielas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Dora Rozanowski (Address) 803 S Dallas St

15 Filed 4-1930 G. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1929, to Feb 3, 1930.

That I last saw h[illegible] alive on Feb 3, 1930

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Rozanowski ✓

Chronic Myocarditis & Congestion

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Pneumonia & Influenza

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & symptoms

(Signed) [illegible] D Prokopf, M. D.

, 19 (Address) 1426 North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL Feb 5 1930

20 UNDERTAKER [illegible] M. W. & Dupre Inc

ADDRESS 32 Lanvale

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53696

CERTIFICATE OF DEATH

101-901 ✓

E 53696

REGISTERED NO. 42-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2471 Druid Hill Ave (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Gray —

(a) RESIDENCE NO. 2471 Druid Hill Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth E Gray

6 DATE OF BIRTH (month, day, and year) June 3 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) in Garage

(c) Name of employer S E Lambert

9 BIRTHPLACE (city or town) Calvert Co

(State or country) Maryland

PARENTS

10 NAME OF FATHER Guy Gray

11 BIRTHPLACE OF FATHER (city or town) Calvert Co

(State or country) Maryland —

12 MAIDEN NAME OF MOTHER Carrie Patterson

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co

(State or country) Maryland

14 Informant Ruth Gray —

(Address) 2471 Druid Hill Ave

15 Filed FEB 4 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb - 2 - 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/31, 1930, to 2/2, 1930, that I last saw h[illegible]ive on 2/1, 1930, and that death occurred, on the date stated above, at 6 20 a m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dan Strunden M. D.

2/4, 1930 (Address) 1211 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Thos Cem Catonsville DATE OF BURIAL Feb 5 1930

20 UNDERTAKER Samuel Beasley & Bro ADDRESS 518

Cor.—12-8-25—A Co.—200 Bks.

E 53697

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53697

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 3915 Falls Rd St.) 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes L Bird

(a) RESIDENCE NO. 3915 Falls Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Horace S Bird

6 DATE OF BIRTH (month, day, and year): Oct 24 1858

7 AGE — Years: 71 Months: 3 Days: 9 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town): Washington

(State or country): D C

PARENTS

10 NAME OF FATHER: George Sylvester

11 BIRTHPLACE OF FATHER (city or town): Unknown

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Knighton

13 BIRTHPLACE OF MOTHER (city or town): Unknown

(State or country)

14 Informant: A C Bird

(Address): 3915 Falls Rd

15 Filed ....., 19..... C. HAMPSON JONES, M. D. Registrar

Mar 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Valvular Disease of Heart

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) John Thomas [illegible] M. D. (Coroner)

2/5, 1930 (Address) 2032 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Davidsonville Md Date of Burial 2/5 1930

20 UNDERTAKER: W. Cook ADDRESS 1317 St Paul St

Cor.—10-10-29—A Co.—100 Blks.

E 53698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 53698

26-11

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 434 N. Clinton St. (Ward)

2-FULL NAME George V. Handley

(a) RESIDENCE NO. 434 N. Clinton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lena Handley

6 DATE OF BIRTH (month, day, and year) Oct 11/1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51	3	23 22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stage Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer Centuary Theatre

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Amos Handley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Knox

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Lena Handley
(Address) 434 N. Clinton St

15 Filed ..... 19..... C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3/30 [19]32

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Green, M. D.

2/4/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	2/6/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 5 - 1930

Cor.—16-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53699

E 53699

CERTIFICATE OF DEATH

REGISTERED NO. 78

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1705 N. Fulton Ave St. 15-21 (Ward)

2-FULL NAME Agnes B. Muth.

(a) RESIDENCE NO. 1905 N. Fulton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmale	White	Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day and year) Feb 28 1908

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	21	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm F. Muth

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Bayly

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Wm Muth
(Address) 1905 N. Fulton Ave

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Anemia

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Essential Epilepsy

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathology

(Signed) F. W. Luck, M. D.

Feb 4 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 2/6 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 53700 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53700

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1723 N Pulaski St.) 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie R Feely

(a) RESIDENCE NO. 1723 N Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred L Feely

6 DATE OF BIRTH (month, day, and year): Sept. 1868

7 AGE: Years 61; Months 5; Days 4; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Gustavus Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sa

12 MAIDEN NAME OF MOTHER: Angela Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Alfred L Feely 1723 N Pulaski St

FEB 6 - 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3. 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1924 to Feb 3, 1930, that I last saw h[illegible] alive on Feb 3, 1930, and that death occurred, on the date stated above, at 5.a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of Heart.

Arteriosclerosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H J Tom, M. D.

(Address) 6777 N. Monroe

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL: 2/6 1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

233460
E 53701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 53701

REGISTERED NO. 13-57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Martin

(a) RESIDENCE NO. 2172 Woodbury ST. Ave — WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edith Martin

6 DATE OF BIRTH (month, day, and year) Aug 14, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	54	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Works in Balto. T. Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk in Bank

(c) Name of employer 609

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER John L. Martin

11 BIRTHPLACE OF FATHER (city or town) Md —
(State or country)

12 MAIDEN NAME OF MOTHER Martha Martin

13 BIRTHPLACE OF MOTHER (city or town) Md —
(State or country)

14 Informant Friends —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 5 - 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 - 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930, to Feb 2, 1930, that I last saw him alive on Feb 2, 1930, and that death occurred, on the date stated above, at 9 10 a. m.

The CAUSE OF DEATH* was as follows:

Chr. nephritis

Hypertension

Myocardial failure

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Myocardial failure

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes XRN129 1-0

What test confirmed diagnosis? Blood Chem - Kidney function tests

(Signed) Alexander Punton, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

20 UNDERTAKER Peterson & Lane

DATE OF BURIAL Feb 5 1930

ADDRESS 3615 Chestnut Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53702

CERTIFICATE OF DEATH

90 ✓

E 53702

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1203 Smith St. 16-23 Ward)

2-FULL NAME Arthur L. Taylor

(a) RESIDENCE NO. 1203 Smith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Widower

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Aug 25—1879

7 AGE: Years 50 | Months 5 | Days 8 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer:

9 BIRTHPLACE (city or town): Howard Co
(State or country): Md

PARENTS

10 NAME OF FATHER: Washington Taylor

11 BIRTHPLACE OF FATHER (city): Howard Co
(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Dorsey

13 BIRTHPLACE OF MOTHER: Howard Co
(State or country): Md

14 Informant: Annie Brown
(Address): 613 N. Carey St

Filed ....., 19.... C. HAMPSON JONES, M. D.
Registrar

B 5 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) Sudden

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. E. Link, M. D.

Feb 3rd 1930 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Feb. 5, 1930
UNDERTAKER: D. Mrs. K. A. Elliott	ADDRESS: 1725 Ashland Ave

IMPORTANT: Write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Blks.

E 53703

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53703

CERTIFICATE OF DEATH

REGISTERED NO. 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 Laurens ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Williams

(a) RESIDENCE NO. 522 Laurens ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Dora G. Williams

6 DATE OF BIRTH (month, day, and year) April 13, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 07°

(b) General nature of industry, business, or establishment in which employed (or employer) Rubie

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Crew, Va

PARENTS

10 NAME OF FATHER Joseph williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER mary watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Joseph williams

(Address) 522 Laurens St

Filed FEB 6 - 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Feb 2, 1930, that I last saw h[illegible] alive on Feb 1, 1930 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard, M. D.

2/4, 1930 (Address) 2056 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 2/5/1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 53704 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 53704

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2621 N. Charles ST. 17-50 WARD)

2—FULL NAME John H. Geis

(a) RESIDENCE NO. 2621 N. Charles ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

a If married, widowed or divorced HUSBAND of (or) WIFE of Sallie Hammond Geis

6 DATE OF BIRTH (month, day, and year) Dec 12 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn
(State or country) A. A. Co. Md

PARENTS

10 NAME OF FATHER John Geis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary K Stall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant J. Hammond Geis
(Address) 600 Stamford Rd Ten Hills

15 Filed 5-1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1928, to Feb 3, 1930, that I last saw h[illegible] alive on Feb 3, 1930 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension
Chr Myocarditis Ch. Diffuse Nephritis
Chr Enterocolitis
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Clinical Signs

What test confirmed diagnosis?

(Signed) Edmund B Freeman M. D.

19 (Address) 807 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Feb 1930

20 UNDERTAKER Chas. S. Black

ADDRESS 742 W. Northave

Spec.—1-12-23—M&T—500 Bks.

Agnes Slizevicus

E 53705

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53705

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 S PINE ST. 429 WARD)

2-FULL NAME AGNIS SLIZEVICNE

(a) RESIDENCE No. 212 S PINE ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Slizevicus

6 DATE OF BIRTH (month, day, and year) NO. 1889

7 AGE	Years	Months	Days	If LESS than 1 day.... hrs. or .... min.
41	41			

8 OCCUPATION OF DECEASED Housewife 037

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Litvania

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Litvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Litvania

14 Informant Pius Zalpiritis

(Address) 212 S Pinn Street

Filed 5 - 1930, 19 C. HALPERN JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Feb 3, 1930, that I last saw h e alive on Feb 3, 1930, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) M. J. Davidson M. D.

, 19 (Address) 3235 Oldmill Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb. 6 1930

20 UNDERTAKER John Gebhardt — ADDRESS 423 S. Paca St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53706

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53706

CERTIFICATE OF DEATH

REGISTERED NO. 118-0

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Mem. Hosp. (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick W. Lippy

(a) RESIDENCE NO. Valley Road (STREET) Catonsville (TOWN) Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Mrs. Frederick W. Lippy

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Candy manufacturer.

(b) General nature of industry, business, or establishment in which employed (or employer) candy

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Christopher Lippy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Elis. Murbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Deceased.
(Address)

15 Filed 5-1930 G. HAMPSON JONES, M. D. Registrar.
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb-1, 1930, to Feb-3, 1930

that I last saw h~~e~~ alive on Feb-3, 1930

and that death occurred, on the date stated above, at 11 25 P. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis (stercoral)
Intestinal Obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ulcer of Colon

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 2/1/30

Was there an autopsy? Yes.

What test confirmed diagnosis? findings at autopsy

(Signed) W Wimbers Jones, M. D.

2/3, 1930 (Address) 20 E. Baltimore St. Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feby 6 1930

20 UNDERTAKER D. George Schilling & Sons

ADDRESS 1126 E Monument St

Cor.—10-10-29—A Co.—100 Bks.

E 53707

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 VE 53707

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St. 14-20 (Ward)

2-FULL NAME Jane Rich

(a) RESIDENCE NO. 1129 Brunt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Arthur Lesser
(Address) 1330 Argyle Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
3rd degree burns
(Coal Stove)

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Smith M. D.

Feb 9/30 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 2-5 1930

20 UNDERTAKER David Evans

ADDRESS 916 Bond

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

TAPP

E 53708 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 53708

CERTIFICATE OF DEATH.

1 PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) Edmondson Ave (St.) (Ward) 11

REGISTERED NO. 4420

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cardia Tapp

(a) RESIDENCE NO. 1009 Linden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE — Years: 27 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Celie Baker. (Address) 426 Aisquith St

15 Filed ..... 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-23-30, 19 , to 2-4-30, 19 .

that I last saw h alive on 2-4-30, 19 ,

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Lung Abscess Appendicitis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 1-31-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M B Landrey, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 2-5 1930

UNDERTAKER: Daniel Corbin.

ADDRESS 961 Pa ave

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 53709

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53709

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) Lee Wilson S. 11-24 WARD)

2-FULL NAME 710 Lindsay ave

(a) RESIDENCE NO. 710 Lindsay ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1840

7 AGE: Years 90 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W. Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant: Frank Carter

(Address) 712 Lindsay ave

15 Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-24 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/25 1930 to 4-24 1930

that I last saw him alive on 4-24 1930

and that death occurred, on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH* was as follows:

Cardio Nephritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Senility from filling (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. Lee Clein, M. D.

(Address) 924 Mad. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 2-5 1930

20 UNDERTAKER: Daniel Carter

ADDRESS 916 Bo ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Collins

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53710 ✓ E 53710

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 Division St. 14-20 WARD)

2-FULL NAME George H. Collins

(a) RESIDENCE NO. 1627 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie

6 DATE OF BIRTH (month, day, and year) May 11- 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (Engineman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer 086

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER John L. Collins

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Silvia Woodland

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Annie Collins

(Address) 1627 Division St

15 1930 C. H. WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1928, to Feb 2, 1930,

that I last saw him alive on Jan 27, 1930,

and that death occurred, on the date stated above, at 2 10 a. m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey, M. D.

2/4. 1930 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery

DATE OF BURIAL 2/5 1930

20 UNDERTAKER Mrs. Lee H. Holland

ADDRESS 168 Druid Hill

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53711

CERTIFICATE OF DEATH

101-001

E 53711

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 631 W. Mulberry St. 25 Ward)

2-FULL NAME Coleman Jordan

(a) RESIDENCE NO. 631 W Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colord	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, professinn or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ga
(State or country)

PARENTS

10 NAME OF FATHER Harry Jordan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ga

12 MAIDEN NAME OF MOTHER Jane Berryhill

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ga

14 Informant Lillie Fields
(Address) 631 W. Mulberry St

15 Filed FEB 5 - 1930 C. HAMILTON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

2/3. 1930 (Address) 2733 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 2/5 1930

20 UNDERTAKER J. Samuel Schneider

ADDRESS 578 N Bond

Important. See instructions on back of certificate. Be sure to give street and number, or such information as may be of value in locating property described. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. P. S.—500 Blks.

E 53712

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53712

CERTIFICATE OF DEATH

128

1—PLACE OF DEATH Balto City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Braxton

(a) RESIDENCE NO. 528 Druid Hill Av. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas Braxton

6 DATE OF BIRTH (month, day, and year) 9-1-79

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	50	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltz. Md

PARENTS

10 NAME OF FATHER Wm Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mat Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records Balto City Hosp (Address)

15 Filed DEC 5 - 1930 19 ES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-3-30

17 I HEREBY CERTIFY, That I attended deceased from 1-31, 1930 to 2-3, 1930 that I last saw h[illegible] alive on 2-2, 1930 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhage
Nephritis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lupus Vulgaris
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Wm T O'Bryan M. D.

2-3, 1930 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 2/6 1930

20 UNDERTAKER Frank Kennedy 5781 N

ADDRESS Baltimore

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53713 3/E 53713

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 17-25 ST. WARD)

2—FULL NAME Lucinda Henry

(a) RESIDENCE NO. 648 Josephine St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4-30

17 I HEREBY CERTIFY, That I attended deceased from 10-20-28, 19..., to 2-4-30, 19..., that I last saw her alive on 2-4-30, 19..., and that death occurred, on the date stated above, at 11:55P. m.

The CAUSE OF DEATH* was as follows:

(Bronchopneumonia (over)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas W. McCrae, M. D.

2-7, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL 2/6/1930

20 UNDERTAKER Samuel B. Hemsley ADDRESS 5784 Belair Rd

Spec.—2-29-28—L. F. S.—500 Blks.

E 53714

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53714

CERTIFICATE OF DEATH

1—PLACE OF DEATH Hospital for Women of Md. REGISTERED NO. 90

CITY OF BALTIMORE: (No. 16-69 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Edith Marguerite Norris

(a) RESIDENCE NO. 3021 Gwynn Falls Pkwy. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. ? 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48 55		6 5	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Arthur Scott Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Rose Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. Blanche K. Tennahue

(Address) 1620 Boston St.

15 FEB 5 - 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1930 to Feb. 4, 1930 that I last saw her alive Tues. Feb. 4, 1930 and that death occurred, on the date stated above, at 3.25 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Aortic Cardiac Dilatation (duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Hodges, M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 6 1930
20 UNDERTAKER John O Mitchell Sons	ADDRESS 1700 Eutaw Place

Spec.—8-16-29—L. F. S.—100 Bks.

B 53715 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 100-00 E 53715

CERTIFICATE OF DEATH + REGISTERED NO. 235

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bruce Dodge

(a) RESIDENCE NO. Terra Alta, ST. W Va WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown Rosie Hoover Dodge

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER Charles Dodge

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Clara Batty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Records (Address)

15 JOHNS HOPKINS HOSPITAL FEB 5 - 1930 Per THOMPSON-JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to Feb 5, 1930 that I last saw him alive on Feb 5, 1930 and that death occurred, on the date stated above, at 6:25 a m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) 8+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia, Lobular

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 1 Feb 30

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) E. H Compton, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Terra Alta W Va — DATE OF BURIAL Feb 5 1930

UNDERTAKER Mitchell & Jones — ADDRESS 190 Garland Place

Spec.—2-29-28—L. F. S.—500 Bks.

E 53716

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53716

CERTIFICATE OF DEATH

REGISTERED NO. 15-67

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas E. Bowen

(a) RESIDENCE NO. 3106 Walbrook Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret C. Hughes

6 DATE OF BIRTH (month, day, and year) Oct. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 069

(b) General nature of industry, business, or establishment in which employed (or employer) U.S.S. Customs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Thomas C. Bowen

(Address) 1702 Ellamont Ave

15 Filed FEB 5 - 1930, 19 — C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to Feb 3, 1930

that I last saw him alive on Feb 3, 1930

and that death occurred, on the date stated above, at 12 25 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Acute Nephritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate

(duration) yrs. 1? mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Jan. 31, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Arthur Kallenni, M. D.

2/3, 1930 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Feb. 5, 1930

20 UNDERTAKER James O. Mitchell & Son.

ADDRESS 1900 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Bks.

E 53717

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 53717

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3300 Weldon Ave. St. 2-5-76 WARD

2—FULL NAME Margaret Barnes

(a) RESIDENCE NO. 3300 Weldon Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Barnes

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	64	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sandra Barnes

(Address) 3300 Weldon Ave.

15 Filed ..... 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1/30

17 I HEREBY CERTIFY, That I attended deceased from 11/27/29, 19.., to 4/1/30, 19..,

that I last saw her alive on 4/1/30, 19..

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 9 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

probably (Cardiac) (duration) 2 yrs 7 mos. da.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo. Bentley, M. D.

4.4.30 (Address) 1088 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion C

DATE OF BURIAL April 1930

20 UNDERTAKER C. H. Brown's Son

ADDRESS Vox to Monty

Spec.—2-29-28—L. F. S.—500 Bks.

E 53718

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

13 V E 53718

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 7-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Dawson

(a) RESIDENCE NO. 630 Iceland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

FEB 5 - 1930

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1-31-30

17 I HEREBY CERTIFY, That I attended deceased from 1-28, 1930, to 1-31, 1930, that I last saw h.im alive on 1-31, 1930 and that death occurred, on the date stated above, at 11 45 P.m.

The CAUSE OF DEATH* was as follows:

Urinary retention

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pyonephrosis - Broncho pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 1-31-30

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. M. Lumpkin, M. D.

2-1, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Ct	Feb 7 1930
20 UNDERTAKER	ADDRESS
H. R. Brown & Son	108 W. Monday

Cor.—1-12-23—M&T—100 Bks.

Margaret Hardegen

E 53719 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53719

CERTIFICATE OF DEATH.

REGISTERED NO. 1926-4290

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4414 E. Frankford ST. 126 WARD)

2-FULL NAME Margaret Hardegen

(a) RESIDENCE NO 4414 E. Frankford ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13-1875

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	9	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer Father Lesinski

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. A Hardegen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hinkes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Elizabeth Hardegen
(Address) 1433 Gorsuch Ave

15 Filed 5-1930 192 C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Myocarditis (Old)

(No Autopsy)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Feb 5 1930 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 2/6/30 192

20 UNDERTAKER J. E. Lynch ADDRESS Lighthouse

Spec.—8-16-29—L. P. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53720 — 145-001 — E 53720

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital — REGISTERED NO. 11-24

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillie Anderson

(a) RESIDENCE NO. 1031 Eutaw St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Colored	Maried

5a If married, widowed, or divorced (or) WIFE of Edward Anderson.

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Georgia Cox (Address) 1031 N. Eutaw St.

15 FEB 5 - 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/11/30, 19..., to 2/1/30, 19..., that I last saw her alive on 2/1/30, 19..., and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure
Post operative Lung abscess
after Cesarean Section.

..... (duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Thoracoplasty for Lung abscess (duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? 1/11/30 +

Did an operation precede death? Yes Date of 1/31/30

Was there an autopsy? No

What test confirmed diagnosis? X Ray & Sputum Ex.

(Signed) W. B. Peemples, M. D.

2-2, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

20 UNDERTAKER Charles H. Cooper

DATE OF BURIAL 2-5 1930

ADDRESS 5147 Caithness St

Spec—12-23-21—E.B.R.S.—400 Bks.

E 53721 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53721

CERTIFICATE OF DEATH.

9-46 87 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2721 Hugo ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary A Buckmaster

(a) Residence No. 2721 Hugo ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of J H Buckmaster

6-DATE OF BIRTH (month, day and year) Oct 28 1867

7-AGE. 62 yrs. 3 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Alex Lowry

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Mary Reinecker

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs J H Buckmaster

(Address) 2721 Hugo ave

15- 2-5-1930 1930 C HARRISON JONES M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 3 1930

17- I HEREBY CERTIFY, That I attended deceased from Jan 5 1930 to Feb 3 1930

that I last saw her alive on Feb 3 1930

and that death occurred, on the date stated above, at 10 50 m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Pericarditis

(Duration) ..... yrs. ..... mos. 20 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) L Dan Grossman M. D.

2/5 1930 (Address) 511 Park

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Western Cem — DATE OF BURIAL, 2/6/30

20-UNDERTAKER, J J Doherty & Sons — ADDRESS 1318 Light St

Rec 2/5

Spec.—2-29-28—L. F. S.—500 Blks.

E 53722

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53722

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: No. 610 Jasper ST. 17-25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jeannette White

(a) RESIDENCE NO. 610 Jasper ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): W

5a ~~Married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of: Thos. White

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE: Years 73 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond

PARENTS

10 NAME OF FATHER: General Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Jesse Pinkett

(Address) 1412 Druid Hill ave

FEB 5 - 1930 C. HAMPSON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 2/30

17 I HEREBY CERTIFY, That I attended deceased from Jany 20, 1930, to Feby 2, 1930

that I last saw her alive on July 1, 1930

and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) David Evans M. D.

2/4, 1930 (Address) 606 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn

DATE OF BURIAL: February 6 1930

20 UNDERTAKER: Joseph A Sirky

ADDRESS: 409 N Mount St

Spec.—1-30—M. & T.—500 Blks.

E 53723 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53723

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Guilford Ave. ST. 11-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Claypoole.

(a) RESIDENCE No. 1110 Guilford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62,	4,	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress, Fulton 069

(b) General nature of industry, business, or establishment in which employed (or employer) Pajama Factory.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George W. Claypoole.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Bramble.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Sarah W. Rathell.
(Address) 3112 Chesterfield Ave.

15 FEB 5 - 1930. C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1929, to Feb. 4 1930,

that I last saw h.. alive on Feb. 4, 1930,

and that death occurred, on the date stated above, at 10 20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebrovelonosis

Chronic Nephritis (Interstitial)

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage 2 hours

(duration) yrs. mos. m.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) John S. Bishop, M. D.

19 (Address) 12 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Feb 6 1930
20 UNDERTAKER	ADDRESS
A. Howard Evans	38 E. Fayette

Cor.—12-8-25—A Co.—200 Bks.

E 53724

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 ✓ E 53724

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No.) Eastern Ave ow way Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Buzgierski

(a) RESIDENCE NO. 805 S Belnord Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Buzgierska

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retoucher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Own Business, Balto

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER August Buzgierski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Zierske

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Agnes Buzgierska

(Address) 805 S Belnord Ave

FEB 5 - 1930

(Registrar)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) ____ yrs. ____ mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ____ yrs. ____ mos. 1 ds.

(Signed) G O Stades M. D.

(Coroner)

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL N. Hamsters Cem Date of Burial Feb 6 1930

20 UNDERTAKER Stephen J Fratkowski ADDRESS 1000 S Kenwood Ave

C. HARRISON JONES

E 53725 —100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53725 ✓ 43

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Rosenberg

(a) RESIDENCE NO. 1110 Hanover ST., St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47	43	2	18 10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Casimir Rosenberger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Cappillo Carl

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Celia Rosenberg.
(Address) 1110 Hanover St

15 Filed FEB 5 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/4-30

17 I HEREBY CERTIFY, That I attended deceased from 1/18, 19 30, to 2/4/30, 19, that I last saw h[illegible] alive on 2/4/30, 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1/21/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Tenner, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leader Hill — DATE OF BURIAL 2/7 1930

20 UNDERTAKER D. H. McCauley — ADDRESS 418 E. Fort

Spec.—8-16-29—L. F. S.—100 Bks.

E 53726

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 53726

CERTIFICATE OF DEATH

REGISTERED NO. 15-67

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3701 Kate Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Siegmund Sr.

(a) RESIDENCE NO. 3701 Kate Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 6 mos. 16 da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Catherine Siegmund

6 DATE OF BIRTH (month, day, and year) July 19 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tertiaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles J. Siegmund

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fredericka Arbandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Catherine Siegmund

(Address) 3701 Kate Ave

15 Filed FEB 5 1930 HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/4/1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Feb 4, 1930, that I last saw him alive on Feb 4, 1930 and that death occurred, on the date stated above, at 6 12 a.m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. 9 da.

CONTRIBUTORY (Secondary) Acute Nephritis Kidney Disease (duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. E. Hearn, M. D.

(Address) 4 W 39 year Fairmount Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Feby 7 1930

20 UNDERTAKER John Merrick

ADDRESS 2008 Arlington

Cor.—10-10-29—A Co.—100 Bks.

E 53727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 179

E 53727

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., H-30 Ward)

2-FULL NAME Eilen Lois Rogers

(a) RESIDENCE NO. 3000 Dunleer Rd. Dundalk, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22-1927

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	3		13 12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank E. Rogers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Nellie Marsh

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Mr. F. E. Rogers
(Address) 3000 Dunleer Rd.

15 Filed ..... C. HAMPSON JONES, M. D., Registrar

FEB 5 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 4 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Second degree burns of face, right arm, Knees and flrt. Accidental Death (duration) ... yrs. ... mos. ...

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Kelly, M. D.

2/4. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johnstown Pa — DATE OF BURIAL Feby 5 1930

20 UNDERTAKER John Meerich — ADDRESS 2008 Eastern

IMPORTANT. See instructions on back of certificate. Be sure all the items are answered so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

E 53728

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53728

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH St Joseph Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 2-4 ST., WARD)

2-FULL NAME Annie Bardoff.

(a) RESIDENCE NO. 216 S. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): March 1864

7 AGE: Years 65 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book Binder

(b) General nature of industry, business, or establishment in which employed (or employer): J. R. Lommis 064

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City,

PARENTS

10 NAME OF FATHER: Louis E. Bardroff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary E. Tible

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: William Bardroff

(Address) 119 N. Kenwood ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 3rd 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Feb 3, 1930,

that I last saw her alive on Feb 3, 1930,

and that death occurred, on the date stated above, at 6:40 A.m.

The CAUSE OF DEATH* was as follows:

Cardio Renal Disease

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Labor

(Signed) B. A. Baisano, M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemy

DATE OF BURIAL: Feb 6, 1930

20 UNDERTAKER: John A. Moran

ADDRESS: 3000 E. Balto

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

Henry J Nauman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53729 00-00 E 53729

E 53729

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospital REGISTERED NO. 16-3

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry J. Nauman (Nauman)

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clark Nauman Cora Nadpe known

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 ?	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter (Automobile)

(b) General nature of industry, business, or establishment in which employed (or employer) 50 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Nauman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Shrick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed FEB 5 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4-30

17 I HEREBY CERTIFY, That I attended deceased from 1-31-30, 19..., to 2-4-30, 19...,

that I last saw him alive on 2-4-30, 19...

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Delerium Tremens

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harris M. McClean, M. D.

2-5, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Feb 7 1930

20 UNDERTAKER Henry Heuck & Son

ADDRESS 1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53730

CERTIFICATE OF DEATH

129 E 53730

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 E Biddle ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Gately

(a) RESIDENCE NO. 2040 E Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Gately

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Co. 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Not. Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not. Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Marie Gately.

(Address) 2040 E Biddle

15 Filed Feb 5 1930, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 3 1930

17 I HEREBY CERTIFY, That I attended deceased from January 29, 1930, to Feb. 3, 1930, that I last saw him alive on Feb. 2, 1930, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Hypertension, Arteriosclerosis

Trauma 2 days.

Multiple Rib Fractures Uncomplicated

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos Fa Shrine, M. D.

Feb 3, 1930 (Address) 2678 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Harford Road

DATE OF BURIAL Feb. 6 1930

20 UNDERTAKER Henry Storch Sons, Inc.

ADDRESS 130, E Eager St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53731

E 53731

CERTIFICATE OF DEATH

REGISTERED NO. 24-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 Oak Hill ave ST., 4-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F Hoban

(a) RESIDENCE NO. 1921 Oak Hill ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pottery

(b) General nature of industry, business, or establishment in which employed (or employer) Geo Bauers.

(c) Name of employer Va.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER William Hoban.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Jane Lyle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Christian H. Morris

(Address) 1921 Oak Hill ave.

15 Filed B5 1930, 19 C. HALL JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/4/30

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1930, to January 4, 1930, that I last saw him alive on January 4, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Myocardial Insufficiency Cardiosclerosis Edema

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

, 19 (Address) 532 E. 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Jan 7 1930

20 UNDERTAKER Gary J. Rudd ADDRESS 1905 Harford ave

Spec.—8-16-29—L. F. S.—100 Bks.

Carrie Klausman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53732

E 53732

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3624 Greenmount ave 12-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Klausman

(a) RESIDENCE NO. 3624 Greenmount ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: L. Klausman.

6 DATE OF BIRTH (month, day, and year): Jan 27-1846

7 AGE: Years 83 | Months 7 | Days 8 | If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: David Fahnestock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Christina Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Daniel Fahnestock.

(Address) 530 Rondelet Terrace.

15 Filed FEB 5 - 1930 19 C. H. [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-4-30

17 I HEREBY CERTIFY, that I attended deceased from Jan 3rd 1930, to Feb 4th 1930, that I last saw h[illegible] alive on Feb 4th 1930 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal disease - Cardiac Hypertrophy. and Accompanying

(duration) ... yrs. ... mos. ... ds.

CONTRIBU[illegible] (Secondary) Senility

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. P. Byerly, M. D.

, 19 (Address) 504 W. Mount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemty.

DATE OF BURIAL: Feb. 7 1930

20 UNDERTAKER: [illegible] for Rose

ADDRESS: 1735 Harford ave

Spec.—1-10-21—M&T—1500 Rls.

E. 58733 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 58733

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Levinai Hospital ST. 43-59 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Levi

(a) RESIDENCE NO. 2432 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

If married, widowed, or divorced HUSBAND of (or) WIFE of Juliette M. Levi

DATE OF BIRTH (month, day, and year) March 10 1857

AGE Years 72 Months 10 Days 25 If LESS than 1 day hrs. or min. 59

6 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) manfg of

(c) Name of employer Children's Apparel

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Joseph Levi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Babette Uffle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Levi (Address) Mt Wash, Baltimore

15 Filed 5-1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/4 1930.

17 I HEREBY CERTIFY, That I attended deceased from 1/1 1930 to 2/4 1930, that I last saw him alive on 2/4 1930, and that death occurred, on the date stated above, at 10:15 P.M.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1/7/30.

Was there an autopsy? no.

What test confirmed diagnosis? Usual.

(Signed) J. E. Swadman, M. D.

19 (Address) Levi Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL Feb 6 1930

20 UNDERTAKER Levi Sonneborn ADDRESS 111 W Mt Royal

Spec.—8-16-29—L. F. S.—100 Blks.

E 53734

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 53734

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 16-22 ST., WARD)

2—FULL NAME William Ransom

(a) RESIDENCE NO. 1018 Calhoun St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen. laborer and Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Essex Co. (State or country) Va.

PARENTS

10 NAME OF FATHER Joe Ransom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lucy Rowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hospitals

15 Filed ..., 19 ... Registrar

E - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4-30

17 I HEREBY CERTIFY, That I attended deceased from 1-23-30, 19..., to 2-4-30, 19..., that I last saw h. im alive on 2-4-30, 19..., and that death occurred, on the date stated above, at 9 1/2 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Vacute

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

2-4, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Feb 9 1930

20 UNDERTAKER Edm'd. Chase Dow

ADDRESS 1400 Mosher

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53735

E 53735

CERTIFICATE OF DEATH

REGISTERED NO. 18-26 32

1—PLACE OF DEATH Provident Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division ST. WARD)

2—FULL NAME Kenneth Smith

(a) RESIDENCE NO. 1010 Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	5	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Buddy Thompson

11 BIRTHPLACE OF FATHER (city or town) West Point

(State or country) Md

12 MAIDEN NAME OF MOTHER Viola Small Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Viola Small (Mother)

(Address) 1010 Saratoga St

15 Filed 6-1930 G. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930, to Feb 3, 1930, that I last saw h alive on Feb 3, 1930 and that death occurred, on the date stated above, at 12 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis (Tuberculous)

(duration) yrs. about 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Carroll M. McClain, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Feb 6, 1930

20 UNDERTAKER D. Mrs Kate R. Williams

ADDRESS 322 N Schroeder St

Spec—12-23-21—E.B.R.S.—400 Eks.

E 53736 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53736

CERTIFICATE OF DEATH.

Registered No. 161

1-PLACE OF DEATH

City of BALTIMORE: (No. 752 W. Lexington St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Girl Essert

(a) Residence No. ..... St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 2/3/30

7-AGE. ..... yrs. ..... mos. 1 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) Balto. (State or Country) Md.

PARENTS.

10-NAME OF FATHER George Essert

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country) U.S.

12-MAIDEN NAME OF MOTHER Helen Knott

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country) Md.

14- (Informant) .....

(Address) .....

15- Filed FEB 5 1930 19.. C. HAMPSON JONES, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feb. 4th 1930

17- I HEREBY CERTIFY, That I attended deceased from Feb. 3 1930 to Feb. 4 1930

that I last saw her alive on Feb. 3 1930

and that death occurred, on the date stated above, at 2:55 A.m.

The CAUSE OF DEATH* was as follows:

Immaturity (28 wks.)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Frank T. Rougeux M. D.

2/4 1930 (Address) Louis. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND

DATE OF BURIAL. ..... 19..

20-UNDERTAKER. Commissioner Health

ADDRESS FEB 4 - 1930

Instructions on back of certificate.

Fer. Wm. P. .....

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

37-002 ✓ E 53737

53737

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 602 Collett St., 15-59 Ward)

2-FULL NAME Clarence Carter

(a) RESIDENCE NO. 602 Collett St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 2-1930

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
		4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Philip Gough

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Selma Carter

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Selma Carter
(Address) 602 Collett

15 Filed ... 19 ... 19 G. HAMILTON JONES, M. D. Registrar

1930 4534

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

(duration) ...yrs. 4 mos. ...da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. Leslie Taylor, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL ... 19 ...

ADDRESS FEB 5 1930

20 UNDERTAKER

Assistant Health Commissioner

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53738

E 53738

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto. Gen. Hosp. ST. 325 WARD 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dudley Carpenter

(a) RESIDENCE NO. 3308 Tate St. ST., Fairfield WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Carpenter

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27 yrs.	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. C. (State or country)

PARENTS

10 NAME OF FATHER Lige Carpenter

11 BIRTHPLACE OF FATHER (city or town) N. C. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records (Address)

15 FILED 5-1930 By [illegible] Registrar

C. RIMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 2-1930

17 I HEREBY CERTIFY, That I attended deceased from 1-21, 1930, to 2-2, 1930, that I last saw h alive on Feb. 2, 1930 and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Toxemia & Starvation & Cardiac Failure (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of -

Was there an autopsy? no

What test confirmed diagnosis? Widal test

(Signed) E. R. Litsinger, M. D.

2-2 1930 (Address) 1213 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lincolnton N.C.

DATE OF BURIAL Feb 6 1930

20 UNDERTAKER Robt T. Williams

ADDRESS 1515 Eden St

Spec.—8-16-29—L. F. S.—100 Blks.

E 53739 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53739

46

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3201 Elgin Ave. ST. 15-6 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Hildegarde Norris

(a) RESIDENCE NO. 3201 Elgin Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Byrd Norris, Jr.

6 DATE OF BIRTH (month, day, and year) Nov. 13, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Legder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ----

14 Informant John B. Norris, Jr.

(Address) 3201 Elgin Ave.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4-30

17 I HEREBY CERTIFY, That I attended deceased from July, 1928, to 2-4, 1930, that I last saw her alive on 2-3, 1930, and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

CARCINOMA OF CERVIX

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? YES Date of July 1928

Was there an autopsy? No

What test confirmed diagnosis? OPERATION & TISSUE EXAM.

(Signed) Joel L. Jones, M. D.

, 19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem'ty	Feb. 6, 1930
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1900 Eutaw Pl.

John O. Mitchell & Sons

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53740

CERTIFICATE OF DEATH

43 E 53740

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 S. Patterson Park Ave. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin . Dobusiewicz

(a) RESIDENCE NO. 608 S. Patterson Park Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maryanna . Dobusiewicz

6 DATE OF BIRTH (month, day, and year) Nov 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
48	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michael Dobusiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Marryanna, Dobusiewicz

(Address) 608 S. Patterson Park Ave.

Filed B 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1929, to Feb. 4, 1930, that I last saw h/m alive on Feb. 3, 1930, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lip
Metastasis to both sides of neck

(duration) yrs. 1? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Libby, M. D.

, 19 (Address) 443 S Patterson Pk. Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem.

DATE OF BURIAL: Feb. 6 1930

UNDERTAKER: John M Wade

ADDRESS: 401 N Chester St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53741

CERTIFICATE OF DEATH

E 53741

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Hopkins Hospital St. (Ward) 36-1

2-FULL NAME Maria Bertini

(a) RESIDENCE NO. 1203 S. Second St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14/29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Petro Bertini

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Annette Contalopu

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Petro Bertini
(Address) 1203 S. Second St

15 1930 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 3/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acidosis
Meningitis ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/5/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL Feb 6 1930.

20 UNDERTAKER Kendall & Leppert

ADDRESS 2014 E Eden

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—8-16-29—L. F. S.—100 Bks.

E 53742

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53742

CERTIFICATE OF DEATH

24-001

1—PLACE OF DEATH Hopkins Hosp — REGISTERED NO. _____

CITY OF BALTIMORE: (No. St Paul s 31st St. 12-50 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME G. Terry Sinclair

(a) RESIDENCE NO. St Paul s 31st ST., _____ WARD _____ (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
86	87	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk (State or country) Virginia

PARENTS

10 NAME OF FATHER Capt Luther Sinclair

11 BIRTHPLACE OF FATHER (city or town) Norfolk (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lelia Lawlay

13 BIRTHPLACE OF MOTHER (city or town) Norfolk (State or country) Virginia

14 Informant Mrs. Blackistone

(Address) Hopkins Hosp St Paul s 31st St

15 Filed 6-1930 G. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from ____, 1927, to 2-7, 1930, that I last saw h[illegible] alive on 2-7, 1930 and that death occurred, on the date stated above, at 9.00 PM.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

(duration) 10+ yrs. mos. ds.

CONTRIBUTORY (Secondary) CEREBRAL HEMORRHAGE

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John L. Jones, M. D.

2/5 1930 (Address) 129 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Feb 6 1930

20 UNDERTAKER Henry H Jenkins & Son — ADDRESS Richard & Eutaw

Spec.—8-16-29—L. F. S.—100 Blks.

E 53743

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53743

CERTIFICATE OF DEATH

100-001

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 15-22 ST., WARD)

2—FULL NAME Doc Allen

(a) RESIDENCE NO. 1314 Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) 1879 1879.?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51	51.?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Harry Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 6-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-3-30

17 I HEREBY CERTIFY, That I attended deceased from 1-2-30, 19..., to 2-3-30, 19..., that I last saw him alive on 2-3-30, 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

2-4, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 2/6 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pressman St

Spec.—8-16-29—L. F. S.—100 Bks.

Swerdeloff V 10002

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53744

CERTIFICATE OF DEATH

E 53744

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Loyola Southway) (WARD) 15-58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marilyn Beverly Swerdloff

(a) RESIDENCE NO. 2500 Loyola Southway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Sol Swerdloff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Corp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Sol Swerdloff

(Address) 2500 Loyola Southway

Filed 2/6 1930 C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 31 1930, to Feb 6 1930, that I last saw h[illegible] alive on Feb 6 1930 and that death occurred, on the date stated above, at 1st 9 m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Clinical & Lab.

(Signed) Abram J. Breckman, M. D.

19 (Address) 2200 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 2/6 1930

20 UNDERTAKER Jack Levin 1439 E Balto St

ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

E 53745 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53745

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) 15-58 (Ward) 8

REGISTERED NO. 101-901

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Katz

(a) RESIDENCE NO. Sinai Hospital ST., 2815 Rockrose St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Simon Katz

6 DATE OF BIRTH (month, day, and year): Aug 22-1887

7 AGE: Years 42 Months 5 Days 14 If LESS than 1 day, hrs. or min. 13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Samuel Markowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Bogotzky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Simon Katz 2815 Rockrose St

15 Filed 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 5 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 21, 1930, to Feb 5, 1930.

That I last saw h[illegible] alive on Feb 5, 1930,

and that death occurred, on the date stated above, at 10.15 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel J. Kopelman M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 2/7 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53746

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53746

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 N. Charles St., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alverta P. Beck

(a) RESIDENCE NO. 1010 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: James L. Beck

6 DATE OF BIRTH (month, day, and year): Feb. 8, 1856

7 AGE: Years 73 | Months 11 | Days 27 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Kent Co Md.

PARENTS

10 NAME OF FATHER: John Brice

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co. Md.

12 MAIDEN NAME OF MOTHER: Annie Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co Md.

14 Informant: Mrs. Sophie Fisher

(Address) 1010 N. Charles St.

15 Filed ....., 19.... C. HARRISON JONES, Registrar

Rec'd 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1930, to February 4, 1930, that I last saw h.er alive on February 4, 1930 and that death occurred, on the date stated above, at 10.45 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) S. A. K. A Mayer, M. D.

M. S. 1930 (Address) 2438 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls Cem. Kent Co. Md

DATE OF BURIAL: Feb. 7 1930

20 UNDERTAKER: Wm J Pickney & Son

ADDRESS: Norfolk Va

Spec.—2-29-28—L. F. S.—500 Bks.

E 53747 HEALTH DEPARTMENT—CITY OF BALTIMORE

89 ✓ E 53747

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2129 N. Fulton Ave St. 15-59 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Egisto J. Pisani Jr

(a) RESIDENCE NO. 2129 N. Fulton Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Pisani

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 57	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Egisto J. Pisani Sr.

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Susan Hamd

13 BIRTHPLACE OF MOTHER (city or town) City

(State or country)

14 Informant Margaret Pisani

(Address) 2129 N. Fulton Ave

15 Filed ..... 19 ..... Registrar

C. HALSEY WOOD, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-23, 1930, to 2-2, 1930, that I last saw h alive on 1-31, 1930 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Robert Straley, M. D.

19 (Address) 2530 Penna. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Feb 6 1930

20 UNDERTAKER W. J. Tuckner Sons

ADDRESS North Ave

Spec.—1-30—M. & T.—250 Bks.

E 53748

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53748

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. 15-65

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4105 Alto Road ST., WARD)

2-FULL NAME Jennie Calvert Base

(a) RESIDENCE NO. 4105 Alto Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 0 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Base

6 DATE OF BIRTH (month, day, and year) Jan 21-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	0	14	13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Emory Round

11 BIRTHPLACE OF FATHER (city or town) (State or country) Windsor N. Y.

12 MAIDEN NAME OF MOTHER Harriett M. Case

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Massachusetts

14 Informant Mrs R G. Round

(Address) 4105 Alto Rd

15 Filed , 19 1939 C. HAMPSON JONES, M.D. Registrar EKS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Feby 4, 1930, that I last saw her alive on Feby 4, 1930, and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia with gradual heart failure

(duration) yrs. mos 9 ds.

CONTRIBUTORY —

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical symptoms & Phys. Signs

(Signed) J. Wesley Calvert M.D.

2/6, 1930 (Address) 2202 Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Feb 6, 1930

20 UNDERTAKER W. J. Tuckner & Sons — ADDRESS 1-Pa Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53749

E 53749

CERTIFICATE OF DEATH

129

23-32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1088 Hanover St. St., Ward

2-FULL NAME Louis Plitt.

(a) RESIDENCE NO. 1088 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. —mos.—ds. How long in U. S., if of foreign birth? 76 yrs. —mos.—ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Dorothea Plitt.

6 DATE OF BIRTH (month, day, and year) October 5th. 1888

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	91	3	30 29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER David Plitt.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Dorothea Wagner.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Dorothea Plitt, (daughter)
(Address) 1088 Hanover St.

15 Filed ..., 19... C. HILLSON JONES, M. D. Registrar

2-5-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4th. 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Eisenhardt, M. D.

2/5, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Co. Cem

DATE OF BURIAL Feb 7 1930

UNDERTAKER C. Schlosman & Son

ADDRESS 1034 Hanover

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53750 HEALTH DEPARTMENT—CITY OF BALTIMORE

100 - 21 / 53750

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Aisquith St. 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Beckie Sacks

(a) RESIDENCE NO. 1409 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Sacks

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hannah Leah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Simon Sacks

(Address) 1409 Aisquith St

15 Filed ... 19 ... Per ... Registrar

C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930, to Feb 5, 1930, that I last saw her alive on Feb 4, 1930 and that death occurred, on the date stated above, at 1.50 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) 1 yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ... yrs. ... mos. 12 hrs

18 Where was disease contracted if not at place of death? 611 So. Howard St

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Edward P. Smith M. D.

2/5, 1930 (Address) 920 St. Paul St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew

20 UNDERTAKER Hof Furnston + Bro

DATE OF BURIAL Feb 6. 1930

ADDRESS 1127 E. Balto St

Cor.—10-10-29—A Co.—100 Bks.

E 53751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 53751

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hawkins' Point Road, Curtis St. 25-77 Ward)

2-FULL NAME Louvinia Moore or Hall.(C)

(a) RESIDENCE NO. Hawkins' Point Road Curtis Bay. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married.

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of Hezi Moore.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44	------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Solley. A. A. Co. Md
(State or country)

PARENTS

10 NAME OF FATHER ------- Hall.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Solley, A. A. Co. Md

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Mrs. Ross.(C)
(Address) Hawkins' Point Rd. Curtis Bay.

15 Filed ..... 1930 ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leonard, M. D.

2/5, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Solley a. a. co. mech. cemetery — DATE OF BURIAL Feb 7 1930

20 UNDERTAKER Edward Bryan — ADDRESS 1691 Orleans st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53752

CERTIFICATE OF DEATH

90

E 53752

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 372 S. Macon ST., 6-10 WARD)

2—FULL NAME Josephine Poskocil

(a) RESIDENCE NO. 211 N. Duncan ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Poskocil

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Frank Berry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Joseph Poskocil

(Address): 211 N Duncan St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 5/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1930, to Feb. 5, 1930, that I last saw her alive on Feb. 5, 1930, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease, associated with arterio-sclerosis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) E. [illegible] Bronnenberg, C. M. D.

2-6-1930 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb. 8 1930

20 UNDERTAKER: Frank Grach & Son — ADDRESS: 1906 Holland Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-003

E 53753

CERTIFICATE OF DEATH.

E 53753

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) Lanvale & Aisquith ST. WARD

2-FULL NAME Baby Ray Wiethling

(a) RESIDENCE NO. 1643 Carswell ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 5 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 31, 1930

7 AGE Years Months Days 5

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER E. R. Wiethling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edwin R. Wiethling

(Address) 1643 Carswell

15 Filed , 19 Registrar C. HAMPSON JONES, M.D.

2-10-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-31-30, 19 , to 2-3-30, 19 .

that I last saw h alive on 2-5-30, 19

and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Stenosis of Pylorus & Congenital Atresia of Colon (duration) yrs. mos. Birth

CONTRIBUTORY (Secondary) Cyanosis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? yes Date of 2-5-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M. Wiethling, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Feb 7 1930

20 UNDERTAKER Frank V. Pipitone

ADDRESS 2915 E Baltimore St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53754

CERTIFICATE OF DEATH.

17° E 53754

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) University Hospital St. 17-25 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William R. Poist

(a) RESIDENCE NO. 637 W. Franklin St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced RUSBAND of (or) WIFE of Alice M. Poist

6 DATE OF BIRTH (month, day, and year) November 20, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	49	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hat Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Young Bros., New York

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Dr. William Bernard Poist

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Minnie E. Baker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Alice M. Poist

(Address) 637 W. Franklin St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Revolver wound of head.
Suicide.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Eugene Gilbert, M. D.
(Coroner)

2/5 1930 (Address) 2739 Eastern Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 637 W. Franklin St.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

Date of Burial Feb. 7 1930

20 UNDERTAKER Joseph H. Cook

ADDRESS 1003 West Baltimore St.

FEB 7 1930

HARRISON JONES, M. D.

very important. See instructions on back of certificate. [illegible] statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Blks.

E 53755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 53755

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 505 N Fremont ST. 27-30 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Singer

(a) RESIDENCE NO. 505 N Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Singer

6 DATE OF BIRTH (month, day, and year): Feb 9 185[illegible]

7 AGE: Years 79 | Months 11 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ostel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Christopher Boekelman

(Address) 505 N Fremont St

15 Filed [illegible] 19 C. HAMPSON JONES, JR. Registrar

SBG - [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929 to Feb. 4, 1930

that I last saw h[illegible] alive on Feb. 4, 1930

and that death occurred, on the date stated above, at 11:00 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis 5 yrs

Chr. Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Urinary & Blood

(Signed) J M D'Esopo M. D.

Feb 5. 1930 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: United Evangelical Cem

DATE OF BURIAL: Feb 8 1930

20 UNDERTAKER: Jos Jacobs & Son

ADDRESS: 2073 S. Pace

Spec.—2-29-28—L. F. S.—500 Bks.

E 53756 ✓ E 53756

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 307 E North Ave ST. 17 WARD)

2—FULL NAME Annie Lindsay Harris

(a) RESIDENCE NO. 307 E North Ave ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 74 yrs. 2 mos. 30 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. C. Harris

6 DATE OF BIRTH (month, day, and year): Nov-6-1855

7 AGE: Years 74 | Months 2 | Days 29 30 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Williams Bend Louisiana

PARENTS

10 NAME OF FATHER: Wm. S. Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown Louisiana

12 MAIDEN NAME OF MOTHER: Mary Stanford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Mississippi

14 Informant: Mr. Thos. C. Harris Husband
(Address) 307 E North ave.

15 [illegible] C. HARRISON JONES [illegible]

FEB 6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 5, 30

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1929, to Feby 5, 1930, that I last saw h[illegible] alive on Feby 5, 1930, and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Arteriosclerosis. (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral hemorrhage (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? no.

(Signed) Hugh Forsythe, M. D.

2/6, 1930 (Address) 4145 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Raleigh N. C. | DATE OF BURIAL: Feb 7 1930

20 UNDERTAKER: Stewart & Company | ADDRESS: Balto

Spec.—2-20-28—L. F. S.—500 Blks.

Rysat Pietrowski 161-002

E 53757

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53757

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 506 S Bradford ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rysat Pietrowski

(a) RESIDENCE NO. 506 S Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 5 - 30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 000

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Rysat Pietrowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Kenik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant T. Pietrowski

(Address) 506 S Bradford

15 Filed 19 C. HARRISON JONES, M. D. Registrar

B 6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 5 - 30

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 19 30 to Feb 5 19 30 that I last saw h— alive on Feb 5 19 30 and that death occurred, on the date stated above, at 11:30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Asphyxia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Breach presentation.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Szydlicki M. D.

(Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL Feb 6 1930

20 UNDERTAKER J. W. Ozoserwski — ADDRESS 1920 Eastern Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53758

CERTIFICATE OF DEATH

167-001

E 53758

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1301 Light St. St. 24-33 Ward)

2-FULL NAME Charles F. Miller.

(a) RESIDENCE NO. 1301 Light St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 2, 1865.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	64	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Oyster shucker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Matther Miller.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna ----------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant August Miller. (nephew)
(Address) ~~1304~~ 515 N. Highland Ave.

Filed FEB 6 - 1930 C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4th. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning.
Suicide.
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Mentzendorff, M. D.

2/5, 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Feb 8 1930

UNDERTAKER Geo M Smith Son

ADDRESS 811 N Howard

Be sure that the death record is complete, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53759

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53759

CERTIFICATE OF DEATH

REGISTERED NO. 24-001 15-63

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4003 Kate Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Kogler

(a) RESIDENCE NO. 4003 Kate Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Kogler

6 DATE OF BIRTH (month, day, and year) Aug. 7, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6 5	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

PARENTS

10 NAME OF FATHER Peter Schuster

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant John M. Kogler

(Address) 4003 Kate Ave.

FEB 6 - 1930 C. HERBERT JONES

Filed Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 1930.

17 I HEREBY CERTIFY, That I attended deceased from June, 19 25, to Feb 4, 1930.

that I last saw h[illegible] alive on Feb 4, 1930

and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Emma E. Wagner, M. D.

2/5, 1930 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Redeemer Cemetery	Feb 7, 1930
20 UNDERTAKER	ADDRESS
Martin Faber & Sons	1827 N. North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

(Serecipous)

E 53760

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 53760

CERTIFICATE OF DEATH

REGISTERED NO. 16-68

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1000 Whitmore ave ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Serricous Franklin Wantz

(a) RESIDENCE NO. 1000 Whitmore ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Margaret Wantz

6 DATE OF BIRTH (month, day, and year) Nov 28th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tempter Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) Otis

(c) Name of employer Self Laurel Md

9 BIRTHPLACE (city or town) (State or country) Laurel Md

PARENTS

10 NAME OF FATHER Noah E. Wantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Laurel Md

12 MAIDEN NAME OF MOTHER Mary Humbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Laurel Md

14 Informant Sophia Margaret Wantz

(Address) 1000 Whitmore ave

15 FEB 6 - 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/2, 1930, to 2/5, 1930,

that I last saw h alive on 2/3, 1930

and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kilpatrick Laurel Co

DATE OF BURIAL 2/7/1930

20 UNDERTAKER Geo Weber & Son

ADDRESS 2503 Edmondson

Spec.—8-16-29—L. F. S.—100 Bks.

E 53761

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53761

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH Balto. City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 26-37 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Wherrett

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) June 16, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73 ?	8 7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 10 0 3

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Wherrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate E. West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed , 19 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-4-30

17 I HEREBY CERTIFY, That I attended deceased from 9-17-27, 19, to 2-4-30, 19,

that I last saw him alive on 2-4-30, 19

and that death occurred, on the date stated above, at 6 P.M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLaw, M. D.

Balto. City Hosp.

2-5, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 2/7/1930

20 UNDERTAKER Wm Cook 1217 St

ADDRESS Paul St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53762

E 53762

CERTIFICATE OF DEATH.

46

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3E. Preston ST. 11-15 (WARD)

2-FULL NAME Mary Agnes Nolan

(a) RESIDENCE NO. 3E. Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. — How long in U. S., if of foreign birth? ——yrs. ——mos. —— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 20 - 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56	55	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sewing.

(b) General nature of industry, business, or establishment in which employed (or employer) 9 — 069

(c) Name of employer —

9 BIRTHPLACE (city or town) Norfolk. (State or country) Virginia.

PARENTS

10 NAME OF FATHER Thomas Andrew Nolan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nicholson

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Mrs Annie Dewall (Address) 3E. Preston St

15 Filed AUG 6 1930, 19 Per ..... Registrar

C. HARRISON JONES, Jr.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1926, to Feb 5th 1930.
that I last saw her alive on Feb 5th, 1930
and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
General Carcinomatosis -
Carcinoma Ovary -

(duration) 4 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Balto.
Did an operation precede death? Yes Date of Nov 25
Was there an autopsy? No
What test confirmed diagnosis? Specimen following op.

(Signed) Robert W Johnson D. M. D.
Feb 6 1930 (Address) 4 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 2/7 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53763 — 90 — E 53763

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hospital ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2—FULL NAME Mrs. Margaret Seipp

(a) RESIDENCE NO. 2201 Ashton St. ST., Balto. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Louis Seipp

6 DATE OF BIRTH (month, day, and year) July 31st 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER John Kalar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Seipp

(Address) 2201 Ashton St

15 Filed 1930 C. H. WILSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/4/30, 19..., to 2/5/30, 19...,

that I last saw h[illegible] alive on 2/5/30, 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Ludwig's angina

(duration) ... yrs. ... mos. 21 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 2/4/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms & Laboratory findings

(Signed) Wm B Schreiber, M. D.

, 19 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2/8/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53764 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53764

CERTIFICATE OF DEATH

REGISTERED NO. 10/200

1—PLACE OF DEATH Balto. City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4-16-30 ST. WARD)

2—FULL NAME Christopher C. Gardner

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct. 4, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75 ?	2 4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer George DeSnields

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER James C. Gardner

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia A. Wagner

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of (Address) Balto. City Hospitals

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5-30

17 I HEREBY CERTIFY, That I attended deceased from 4-16-30, 19..., to 2-5-30, 19..., that I last saw h... alive on 2-5-30, 19..., and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin W. McLean, M. D.

2-5, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bachmans Cemetery — DATE OF BURIAL 2/8/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Blks.

233427 E 53765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 53765

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 27-53 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E Coale

(a) RESIDENCE NO. 500 Overhill Rd Roland Park ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 30 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Colston

6 DATE OF BIRTH (month, day, and year): Feb 7-1860

7 AGE — Years: 69 | Months: 11 | Days: 30 29 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Broker

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William E Coale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Louise Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed FEB 10 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Feb 6, 1930, that I last saw h.im alive on Feb 6, 1930, and that death occurred, on the date stated above, at 4.27 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gen usable laboratory

(Signed) R. Hooper Lovett, M. D.

Feb 6 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: Feb 7th 1930

20 UNDERTAKER: Henry H. Perkins Sons

ADDRESS: McCulloh & Richard Sts

Spec.—8-16-29—L. F. S.—100 Blks.

E 53766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 53766

1—PLACE OF DEATH Greenway Apts

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 34 E. Chase St. 12-4-9 WARD)

2—FULL NAME Charles Landfield Hyatt

(a) RESIDENCE NO. Greenway Apts ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 3 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Meta Hutton

6 DATE OF BIRTH (month, day, and year) Oct 11 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
64	67	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Chas. Hyatt

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Lisa Lineland

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Chas. L. Hyatt Jr.
(Address) Greenway Apts.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 5. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 3, 1930 to Feby 5, 1930, that I last saw h alive on Feby 5, 1930 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage with hemiplegia.

..... (duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) arterio sclerosis.

..... (duration) 15 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Harry H McCarty, M. D.

Feby 6, 1930 (Address) 37 W. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL Feb 7 1930

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh & Richard St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53767

E 53767

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 745 W. Mulberry St., 4-Ward)

2-FULL NAME Elizabeth David Moulton

(a) RESIDENCE NO. 745 W. Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Moulton

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 90
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Blanche Spurting
(Address) 745 W. Mulberry

15 Filed ..... 19..... Registrar

E-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb. 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zelley, M. D.

2/6, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn et

DATE OF BURIAL Feb 8 1930

20 UNDERTAKER J. L. Brown & Son

ADDRESS 108 W. Monte

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 53768

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53768

CERTIFICATE OF DEATH.

REGISTERED NO. 25-32 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Mills

(a) RESIDENCE NO. 2803 Indiana Ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 8 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White ~~Colored~~	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) May 27-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Adolphus Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed 1930. 19 C. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5-30

17 I HEREBY CERTIFY, That I attended deceased from 1-9, 1930, to 2-5, 1930, that I last saw him alive on 2-5, 1930, and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Senility - Generalized Arteriosclerosis

(duration) Unknown

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Turnbull, M. D.

2-5, 1930 (Address) Baltimore City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 2/7/1930

UNDERTAKER John J. Howard & Son

ADDRESS 901 Hollins St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53769

101-001

E 53769

CERTIFICATE OF DEATH

REGISTERED NO. 37-44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4411 Mainfield Ave ST., WARD 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie White

(a) RESIDENCE NO. 4411 Mainfield Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced BUSBAND of (or) WIFE of Geo E. White

6 DATE OF BIRTH (month, day, and year) July 29/1877

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Fred. Kunnecke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Joseph Reardon

(Address) 4411 Mainfield Ave

15 - 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 1930 to Feb 4 1930 that I last saw h[illegible] alive on Feb 4 1930 and that death occurred, on the date stated above, at 2 37 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) L. L. Dorsey, M. D.

2-5, 1930 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Feb 7 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

Spec.—2-29-28—L. P. S.—500 Blks.

E 53770

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53770

CERTIFICATE OF DEATH Vernier 46

REGISTERED NO. 9-46

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 752 Bartlett Av. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mawd La Ponte Vernier

(a) RESIDENCE NO. 752 Bartlett Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 4 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Vernier

6 DATE OF BIRTH (month, day, and year) 1-23-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	—	7 12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 57

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10 NAME OF FATHER Joseph La Ponte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Vernier

(Address) 752 Bartlett Ave

15 FEB 9 - 1930 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5th, 1930, to Feb 4th, 1930, that I last saw h... alive on Feb 4th, 1930 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

and general Asthenia

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Coronary Sclerosis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Phy Footing 17 Bryant

Did an operation precede death? Phy Date of

Was there an autopsy? No

What test confirmed diagnosis? Macroscopic

(Signed) Hugh W. Davis M. D.

, 19 (Address) 16 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Feb 7 1930

20 UNDERTAKER Mary M Wendefeld

ADDRESS 501 E 22nd St

Cor.—10-10-29—A Co.—100 Bks.

E 53771

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53771

CERTIFICATE OF DEATH

105

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH On Stmr. State of Maryland, Bay Line.

City of Baltimore: (No. En Route Norfolk to Baltimore St. 22-6 Ward

2-FULL NAME Frederick Wyman Richardson.

(a) RESIDENCE NO. Cradock, Portsmouth, Va. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Mary V. Richardson.

6 DATE OF BIRTH (month, day, and year) June 4th. 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	49	8	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hot bed Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Portland Me.
(State or country)

PARENTS

10 NAME OF FATHER John Stone Richardson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Jay, Me.

12 MAIDEN NAME OF MOTHER Clara Wyman.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wilbridge, Me.

14 Informant Mary V. Richardson. (wife)
(Address) Cradock, Portsmouth, Va.

15 Filed 19 C. HARRISON JONES, M. D., Registrar.
Per

6 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6th. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Osthma.

Acute dilatation of the Heart.

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Einstadt, M. D.

2/6, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portsmouth Va	2/6 1930
20 UNDERTAKER William Cook	ADDRESS 1217 S. Paca

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53772 — **CERTIFICATE OF DEATH** — 129 — REGISTERED NO. **E 53772**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2703 Hugo. Av. ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna E. Hunn.

(a) RESIDENCE NO. 2703 Hugo. Av. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry E. Hunn.

6 DATE OF BIRTH (month, day, and year) Nov. 22. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Buchheister

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany.
(State or country)

14 Informant Harry E. Hunn
(Address) 2703 Hugo Av

15 Filed 1930, By C. H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1930, to February 4, 1930

that I last saw her alive on February 4, 1930

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation Decompensated
Chronic Interstitial Nephritis
(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos Fa Stevens, M. D.

2/5, 1930 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL Feb 7 1930.

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son

ADDRESS 801 W. Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53773

CERTIFICATE OF DEATH

129 E 53773

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N. Milton ave ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel C. Ford

(a) RESIDENCE NO. 405 N. Milton ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie C. Ford

6 DATE OF BIRTH (month, day, and year) July 17-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	84	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 062

(b) General nature of industry, business, or establishment in which employed (or employer) Night Watchman

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Tobias Ford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mary E. Ford
(Address) 405 N. Milton ave.

15 Filed 6 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 19.. to Feb 4, 1930,

that I last saw h.. alive on Feb 4, 1930

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Senility
Chronic Intestinal Nephritis
(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? do

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin

(Signed) H. Kent Tuttle, M. D.

Feb. 7, 1930 (Address) 1325 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cemetery — DATE OF BURIAL: Feb 7 1930

UNDERTAKER: Wm. Albert E. Fuller — ADDRESS: 4806 Harford ave.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53774

E 53774

CERTIFICATE OF DEATH

161-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2039 Fleet St. ST 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jozefa Potocka

(a) RESIDENCE NO. 2039 Fleet St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 23 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jozef Potocki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Victoria Strycharz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jozef Potocki

(Address) 2039 Fleet St.

Filed ..., 19 ... Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to Feb 5, 1930, that I last saw h[illegible] alive on Feb. 5, 1930 and that death occurred, on the date stated above, at 2a.m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? P.S. & F.

(Signed) John J. Kriegl, M. D.

19 (Address) 2029 East Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. DATE OF BURIAL Feb. 7 1930

20 UNDERTAKER John H. Weber ADDRESS 401 Chester

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53775

E 53775

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Nanticoke ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Octavia M. Mitchell

(a) RESIDENCE NO. 1143 Nanticoke ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-14-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 032

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward R. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Henrietta Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Grace L. Sullivan

(Address) 1143 Nanticoke St

15 Filed ... 1930 C. HARRISON JONES, Jr. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Jan 3, 1930, that I last saw h[illegible] alive on Jan 3, 1930 and that death occurred, on the date stated above, at 1145 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis 5 yrs

Chr. Int. Nephritis

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Sphygmomanometer Exs

(Signed) J. M. Dalsett, M. D.

1930 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Balto

DATE OF BURIAL 1930

20 UNDERTAKER John C. Miller 2435

ADDRESS E Oliver

Spec.—2-29-28—L. F. S.—500 Bks.

E 53776

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 53776

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. General Hosp. ST., 1-16-67 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Lydia Barnes

(a) RESIDENCE NO. 727 Greenley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harrisburg (State or country) Pa

PARENTS

10 NAME OF FATHER Jacob Raff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-30

17 I HEREBY CERTIFY, That I attended deceased from 1-16-30, 19..., to 2-6-30 19..., that I last saw her alive on 2/6/30, 19..., and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Thrombotic Gangrene of
rt. lower extremity.
Chronic myocarditis

(duration) ... yrs. ... mos. 38 da.

CONTRIBUTORY (Secondary) Pyaemia (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

2 (Signed) Jno A Dempster M. D.

1/4 19 (Address) Med Staff Hospl

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk Cem

DATE OF BURIAL 2/8 1930

20 UNDERTAKER J. Ahrens Co

ADDRESS 1923 Fenton Rd

U 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 53772

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53777

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 4-26

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony Ulchinsky

(a) RESIDENCE NO. 709 W. Lexington ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if foreign birth 40 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alonda Ulchinsky

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Lithuania

PARENTS

10 NAME OF FATHER Francis Ulchinsky

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Frans ?

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Lithuania

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-30

17 I HEREBY CERTIFY, That I attended deceased from 1-30-30, 19..., to 2-6-30, 19...,

that I last saw him alive on 2-6-30, 19...,

and that death occurred, on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic & acute

(duration) ... yrs. ? mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) over 9 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? N.P.N. & Clinical

(Signed) Warren M. McLean, M. D.

2-6, 19-30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 2/8/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53778

CERTIFICATE OF DEATH

185 E 53778

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2529 Druid Hill Ave St. W-69 Ward)

2-FULL NAME Margaret Lahner

(a) RESIDENCE NO. 2529 Druid Hill Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1843

7 AGE: Years 87 | Months 10 | Days 28 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town)
(State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Germany

14 Informant: Mrs. Margaret Lahner
(Address)

Filed Feb 6 1930 C. HARRISON JONES, Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental Fall & Lone Fracture of Hip, Hypostatic Pulmonary Congestion (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
Senility (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke M. D.

Feb 6. 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holly Pedemer

DATE OF BURIAL: Feb 7 1930

20 UNDERTAKER: W. H. Cook

ADDRESS: 1717 Ft Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

(Weisman)

E 53779

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53779

CERTIFICATE OF DEATH

REGISTERED NO. 91

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W Wiseman

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	82	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Francis Wiseman

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mary Wall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley Sts

15 Filed 6 1930 G Hamson Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1930, to Feb 6, 1930, that I last saw h... alive on Feb 5, 1930, and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Senility
arteriosclerosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. B. Gemmo Watts, M. D.

2/6, 1930 (Address) 1216 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Solomons, Md.

DATE OF BURIAL 2/8 1930

20 UNDERTAKER Herbert A. Hardesty

ADDRESS Mechanicsville, Md.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

202 E 53780

CERTIFICATE OF DEATH

E 53780

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp St. 22-1 Ward)

2-FULL NAME Joseph Barsky

(a) RESIDENCE NO. 3205 Hudson St., Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Barsky

6 DATE OF BIRTH (month, day, and year) Feb 22-1894

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	35	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steam Fitter
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Hungary
(State or country)

PARENTS

10 NAME OF FATHER Albert Barsky

11 BIRTHPLACE OF FATHER (city or town) Hungary
(State or country)

12 MAIDEN NAME OF MOTHER Julia Barsky

13 BIRTHPLACE OF MOTHER (city or town) Hungary
(State or country)

14 Informant Sophia Barsky
(Address) 3205 Hudson St

15 Filed Feb 28 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an _____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows*
Accident
Fractured Skull
Broken Neck (duration) 0 yrs. 1 hour mos. ds.
CONTRIBUTORY (Secondary) Fell on head
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bethlehem Steel Co
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? _____
(Signed) H. Feinblatt M. D.
Feb. 5 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 2/8/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

important. See instructions on back of certificate.

6 - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 53781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/√ E 53781

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3110 Montebello Ave. ST. 9-46 (WARD)

2—FULL NAME Margaret P. Frater,

(a) RESIDENCE NO. 3110 Montebello Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 3 mos. 16 da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hubert Frater,

6 DATE OF BIRTH (month, day, and year) October 17. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michel Roettenger,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Helen C. Frater (Address) 3110 Montebello Ave

15 Filed ... 19 ... C. HARRISON JONES, Registrar.

2-7-1930 By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 5 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Feb 5, 1930, that I last saw h[er] alive on Feb 5, 1930, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis.

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 3 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo Turgeon M.D.

2/7/1930 (Address) 401 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL FEB 8 - 1930

20 UNDERTAKER D. Geo W. Little

ADDRESS 2700 EDMONDSON AVE.

Spec.—1-30—M. & T.—250 Blks.

Dr Fisher 1800 Washington St

E 53782 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 53782

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2642 Harford Rd ST., 9-46 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosener L. Buffington

(a) RESIDENCE NO. 2642 Harford Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9th yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Buffington

6 DATE OF BIRTH (month, day, and year) Aug 30, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	78	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Laurel Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John F. Buffington

(Address) 2642 Harford Rd

Filed ..., 19 ... Registrar

C. F. C. JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5. 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 24, 1930, to Feb 5, 1930, that I last saw h[illegible] alive on Feb 4, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Arteriosclerosis

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Laurt Fisher, M. D.

2/7, 1930 Address 1812 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 2/7 1930

20 UNDERTAKER H. Cook

ADDRESS 1217 N. Carey St

Spec.—1-30—M. & T.—250 Blks.

E 53783

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53783

CERTIFICATE OF DEATH.

REGISTERED NO. 28-66

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 Swan Ave ST. (WARD)

2-FULL NAME Ada E Murray

(a) RESIDENCE NO. 704 Swan Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fred A Murray

6 DATE OF BIRTH (month, day, and year) Nov 24 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Albert H Munroe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Mary Burnell Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant (Address) Fred A Murray Jr Mt Rainier Md

15 Filed 1930 HILTON JONES, M.D. Registrar

Via RFD — c/o Fred Murray

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6/1930

17

I HEREBY CERTIFY, That I attended deceased from Nov 16, 1929, to Feb 6, 1930;

that I last saw h alive on Feb 6, 1930;

and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Fracture of R Humerus.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility.

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S. Lloyd Johnson, M. D.

, 19 (Address) 420 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasantville N.J. ~~Atlantic Co~~

DATE OF BURIAL Feb 7 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 53784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

21 ✓ E 53784

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Milton Butler

(a) RESIDENCE NO. 1720 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred City yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wilson Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County

12 MAIDEN NAME OF MOTHER Eastana Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West River Md

14 Informant Eastana Butler

(Address) 1720 St. Paul St

FEB 7 - 1930 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 6, 1930, that I last saw him alive on Feb 5, 1930 and that death occurred, on the date stated above, at 5 05 a.m.

The CAUSE OF DEATH* was as follows:

Erysipelas of Face (Idiopathic)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

2-7, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL 2-7-1930

20 UNDERTAKER Harold Easton

ADDRESS 916 Penna. Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53785

CERTIFICATE OF DEATH

24-001 E 53785

REGISTERED NO. 19-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 229 S Streeter ST. (WARD)

2—FULL NAME John Prinz

(a) RESIDENCE NO. 229 S Streeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Becker

6 DATE OF BIRTH (month, day, and year) April 19-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	61	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 60

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Demesvar

(State or country) Austria Hungary

PARENTS

10 NAME OF FATHER Philip Prinz

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Mosler Austria Hungary

12 MAIDEN NAME OF MOTHER Magdalene Bakel

13 BIRTHPLACE OF MOTHER (city or town) Mosler

(State or country) Austria Hungary

14 Informant Barbara Prinz

(Address) 229 S Streeter

DEC - 1930 [illegible] JOHNSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6-30

17 I HEREBY CERTIFY, That I attended deceased from 2/2-, 1930, to 2/6-, 1930

that I last saw h... alive on 2/5-, 1930

and that death occurred, on the date stated above, at 2:40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

4

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas A Erlin, M. D.

2/6, 1930 (Address) 2145 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 2/8 1930

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins

Spec.—1-10-21—M&T—1500 Bks.

E 53786

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53786

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1417 Whitelock (WARD) 43-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Tolson

(a) RESIDENCE NO. 1417 Whitelock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith M.

6 DATE OF BIRTH (month, day, and year) Dec 25-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edith M. Tolson (Address) 1417 Whitelock

15 Filed FEB 7 1930, O. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 27 1929 to Feb 6 1930,

that I last saw h— alive on Feb 6th 1930,

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Nephritis & Valvular Heart disease (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

20 (Signed) B. L. French M. D.

2/7, 1930 (Address) 707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 2/9/1930

UNDERTAKER Wm. H. Holland — ADDRESS 1631 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 53787

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital) WARD 17-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Cansell

(a) RESIDENCE NO. 1046 Argyle Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) ? 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Briscoe

(Address) Bishop Road Harwood

FEB 7 - 1930 HARRISON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-30

17 I HEREBY CERTIFY, That I attended deceased from 12-13-, 1929, to 2-6-, 1930, that I last saw h. alive on 2-6-, 1930 and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows: Carcinomatosis

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Parkinson, M. D.

2/6, 1930 (Address) 600 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery

DATE OF BURIAL 2/9/1930

20 UNDERTAKER Wm. H. Holland

ADDRESS 1631 Druid Hill

Spec.—8-16-29—L. F. S.—100 Bks.

E 53788 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

75-002

E 53788

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Argyle Ave ST. 11-20 WARD)

2—FULL NAME Josephine Lyons Graham

(a) RESIDENCE NO. 1402 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 4 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Graham

6 DATE OF BIRTH (month, day, and year) Sept. 3-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Nathaniel Lyons

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Sharon Wilson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Ewa Brayton

(Address) 1402 Argyle Ave

15 Filed FEB 7 - 1930, 19 CHARLTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-5-30

17 I HEREBY CERTIFY, That I attended deceased from 1-28-, 19 30, to 2-5, 19 30, that I last saw alive on 2-4, 19 30 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Paraplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

2-4, 19 30 (Address) 425 N. Carlton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lawn

DATE OF BURIAL Feb 5 1930

20 UNDERTAKER Sam'l H. Chase Son

ADDRESS 1400 Mosher

Spec.—1-12-23—M&T—500 Blks.

E 53789

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53789

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. 24-35

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1234 Fork Ave ST. 24 WARD 5

2-FULL NAME Robert W. Harrison

(a) RESIDENCE NO. 1234 Fork Ave ST., 24 WARD 5

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence R. Harrison

6 DATE OF BIRTH (month, day, and year) July 4. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Florence R. Harrison

(Address) 1234 Fork

Filed FEB 7 1930

C. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5th 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1930, to Feb. 5th, 1930, that I last saw h— alive on Feb. 4, 1930, and that death occurred, on the date stated above, at 9:=0 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Wm. T. Seabury, M. D.

2/6, 1930 (Address) 636 Fork Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park.

DATE OF BURIAL Feb 8th 1930

UNDERTAKER Fred A. Wanaley

ADDRESS 703 Hanover

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

F 33624
F 537 0

HEALTH DEPARTMENT—CITY OF BALTIMORE

123 E 53790

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jodie C Stondenmire

(a) RESIDENCE NO. 22 E. 24th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Oct 7-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truant Officer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry H Cowles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Matilda Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lorenda C Stondenmire

(Address) JOHNS HOPKINS HOSPITAL 1518 Mt Royal ave

15 C. HAMPSON JONES, M.D. Registrar

FEB 7 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1929, to Feb 6, 1930, that I last saw her alive on Feb 6, 1930 and that death occurred, on the date stated above, at 5-45 A m.

The CAUSE OF DEATH* was as follows:

Pyrexia of Unknown Origin

(duration) 1 yrs. 6 mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan. 20 1930

Was there an autopsy? Yes Renal & Gall Stones

What test confirmed diagnosis?

(Signed) Alexander Forster, M. D.

2/6, 1930 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

UNDERTAKER Geo Schilling & Sons

DATE OF BURIAL Feb 8th 1930

ADDRESS Monument Sq

Spec.—1-10-21—MAT—1500 Blks.

E 53791

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 53791

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) St. Joseph's Hospital (St.) 1-3 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Teresa Bates

(a) RESIDENCE NO. 2219 Bayview St. (St.) (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE — Years: 59 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Rohrer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Had Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mrs. Isaac H. Ludwig

(Address) 152 E. Kenwood

15 Filed FEB 7 - 1930 L. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to Feb 6, 1930, that I last saw her alive on Feb 6, 1930, and that death occurred, on the date stated above, at 11:15 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Epidermis Clitoris

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1-29-30

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL Feb. 8 1930

D UNDERTAKER Jos. J. Kerr — ADDRESS 106 N. Luzerne

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

B 53792 16 1-001 B 53792

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1930 W. Pratt St. 20-28 Ward

2-FULL NAME John R Wiseman

(a) RESIDENCE NO. 1930 W Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Sophie Pfeiffer

6 DATE OF BIRTH (month, day, and year) Oct. 19 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51	3	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country) Georgia Wiseman

PARENTS

10 NAME OF FATHER Germany

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Cassandra Shipley

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Sophie Wiseman
(Address) 1930 W Pratt St

15 Filed FEB 7 1930 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au- Inquest find that said deceased came to death topsy or inquiry)
on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide at home Asphyxiation by illuminating gas

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

Feb 8, 1930 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feb 8 1930
UNDERTAKER George L. Schwartz	ADDRESS [illegible]

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blo.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53793

CERTIFICATE OF DEATH.

90 ✓ E 53793

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Born Ct. ST. 19-27 WARD)

2-FULL NAME Catherine Snell

(a) RESIDENCE NO. 1402 Born Ct. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dennis Snell

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	Abt. 70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Howard Co. Md.

PARENTS

10 NAME OF FATHER: Samuel Snell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co. Md.

12 MAIDEN NAME OF MOTHER: Eliza Snell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co. Md.

14 Informant: Mrs. Kate Williams

(Address): 322 N. Schroeder St.

15 FILED 7-1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 4th. 19 30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 27th. 1929 to Feb. 4th. 1930.

that I last saw h e alive on Feb. 3rd. 1930

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 2 mos 11 ds.

CONTRIBUTORY (Secondary): Mitral Ins.

(duration) 1 yrs. Unknown ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Feb. 7. 1930

20 UNDERTAKER: Mrs Kate R. Williams — ADDRESS 322 N Schroeder St

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 53794 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53794

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE, (No.) 1122 N. Carey St (or WARD) 16-23

2-FULL NAME James Jenkins

(a) RESIDENCE No. 1122 N. Carey St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Jenkins

6 DATE OF BIRTH (month, day, and year) Dec 28, 1879

7 AGE	Years	+ Months	Days	+	If LESS than 1 day, ... hrs. or ... min.
	50	1	6	+	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Baltimore Co Public

9 BIRTHPLACE (city or town) Unknown
(State or country) Harford Co

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Eliza Jenkins
(Address) 1122 N. Carey St

15 Filed FEB 7 - 1930 C. H. PERSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930, to Feb 4, 1930, that I last saw h... alive on Feb 4, 1930, and that death occurred, on the date stated above, at 11.15P m.

The CAUSE OF DEATH* was as follows:

Influenza
(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Fullerton Md,
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical

(Signed) W. T. Fairgrieve, M. D.
2/5, 1930 (Address) 1209 Kresheim

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Hill Cem
DATE OF BURIAL 2-7-30
ADDRESS 915
20 UNDERTAKER Sam Carter

Spec.—1-10-21—M&T—1500 Rks.

E 53795 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53795

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2230 W. Hamburg ST. 25-72 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Kendler,

(a) RESIDENCE NO. 2230 W. Hamburg ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Kendler

6 DATE OF BIRTH (month, day, and year): — 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	—

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 37
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS
10 NAME OF FATHER: Gus Emley
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.
12 MAIDEN NAME OF MOTHER: Elizabeth Stein
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Charles Kendler 2230 Hamburg

15 Filed ..... 19 28 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 1, 1929 to February 5, 1930, that I last saw her alive on February 5, 1930, and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

duration 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Stevens, M. D.

2/5, 1930. (Address) 1901 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 2/8 30

UNDERTAKER: Edward Jones — ADDRESS: 22 W. Saratoga

H. HANSON JONES, M.D.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 53796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 53796

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1106 Madison Ave. Ward 11-2)

2-FULL NAME Carrie Steinkuin

(a) RESIDENCE NO. 1106 Madison Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: do not know

6 DATE OF BIRTH (month, day, and year): July 1882

7 AGE: Years 49 | Months 6 | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic.
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Jos. Burrell

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Mckeown

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Walter Dr. Liddle
(Address): 334 W. Fayette

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Feb 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) ..... yrs. 2 mos. ..... da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Regular

What test confirmed diagnosis?

(Signed) F. H. Luick, M. D.

Feb 19 30 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 2-7-30

20 UNDERTAKER: Dennstedt

ADDRESS: 916 Cathedral

FEB 7 1930 C. HAMPSON JONES

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53797

CERTIFICATE OF DEATH

117 ✓

E 53797

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 13-5 WARD)

2—FULL NAME Mrs. Anna Miller

(a) RESIDENCE NO. 713 W. 37th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of— (or) WIFE of Mr. Irvin Miller.

6 DATE OF BIRTH (month, day, and year) 1/21/1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. City

(State or country)

PARENTS

10 NAME OF FATHER Eli N. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Co., Md.

12 MAIDEN NAME OF MOTHER Lenora Martin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balt. Co. Md.

14 Informant Hospital record

(Address)

15 Filed 2-7-1930 C. H. Mackey Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-30

17 I HEREBY CERTIFY, That I attended deceased from 1-29, 1930, to 2-6, 1930, that I last saw h[er] alive on 2-6, 1930 and that death occurred, on the date stated above, at 1235 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Chronic Nephritis

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 1-30-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

2/4/30 (Signed) Jno. A. Crompton M. D.

(Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem.

DATE OF BURIAL Feb 8 1930

20 UNDERTAKER Thomas F. Kane & Sons

ADDRESS 3617

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53798

CERTIFICATE OF DEATH

129 E 53798

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3664 Ash St. ST. 13-57 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Louise Cooper.

(a) RESIDENCE NO. 3664 Ash St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late) Holmes Cooper.

6 DATE OF BIRTH (month, day, and year) March 30,185

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Mchalske

11 BIRTHPLACE OF FATHER (city or town) (State or country) Australia

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant William H. Whiteley.

(Address) 1534 N. Washington St.

15 Filed (C. H. [illegible]) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10th, 1930, to Feb 5th, 1930, that I last saw h[illegible] alive on Feb 5th, 1930 and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Bronch-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility. Chronic Int Nephs. C.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hyaline Casts & Pus

(Signed) F. E. O-Fallon, M. D.

2/6, 1930 (Address) 3614 Falls Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden.

DATE OF BURIAL Feb 7, 1930

20 UNDERTAKER C. Thomas Talon

ADDRESS 3615 Chestnut

Spec.—2-29-28—L. F. S.—500 Bks.

E 53799 HEALTH DEPARTMENT—CITY OF BALTIMORE + 47 ✓ E 53799

CERTIFICATE OF DEATH

REGISTERED NO. 12-47

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hosp ST. 12-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Rosalie Cannell

(a) RESIDENCE NO. Elizabeth N. J. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Alexander Cannell

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER J. Tyde Turnbull

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Willie Harrison

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs. James Cannell
(Address) Elizabeth N. J.

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1930, to Feb. 6, 1930

that I last saw her alive on Feb. 6, 1930

and that death occurred, on the date stated above, at 8:55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (R.)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Elizabeth, N. J.

Did an operation precede death? Yes Date of May, 1929.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) A. R. Wilkerson, M. D.

2/6, 1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmanuel Church Cem Glencoe Md

DATE OF BURIAL Feb 8 1930

20 UNDERTAKER Henry Wenkins & Son

ADDRESS Cathedral & Mt. Vernon Pl

Spec.—8-16-29—L. F. S.—100 Bks.

E 53800 ✓ E 53800

E 53800 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. _____

CITY OF BALTIMORE: (No. 1022 N. Calvert ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Imogene Piper

(a) RESIDENCE NO. 1022 N. Calvert ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Dr Jackson Piper

6 DATE OF BIRTH (month, day, and year) April 19 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	82	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER W. S. Sholmaker

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Phila Pa

12 MAIDEN NAME OF MOTHER Emma R. Grace

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Baltimore Co Md

14 Informant James. Piper
(Address) 1637 Balto Tr. Bldg

15 Filed _____ 19 _____ C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1st 1930

17

I HEREBY CERTIFY, That I attended deceased from _____, 19 26, to 2-6, 19 30,

that I last saw h[illegible] alive on 2-6, 19 30

and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

LOBAR PNEUMONIA

_____

_____

_____ (duration) — yrs. — mos. 4 ds.

CONTRIBUTORY _____
(Secondary)

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) John T. Jones, M. D.

2/7, 1930 (Address) 1129 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park Cem	Feb 8th 1930
20 UNDERTAKER Henry Meukins & Sons Co	ADDRESS Oakland Ex-Called

Spec.—2-29-28—L. F. S.—500 Bks.

E 53801 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 53801

× 137

CERTIFICATE OF DEATH

1—PLACE OF DEATH Homan's Hospital REGISTERED NO. .....

CITY OF BALTIMORE: (No. 14-20 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josefa Noel Crosby Hopkins

(a) RESIDENCE NO. Charles St. ave. ST., Hoodbrook WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. ✓ mos. ✓ ds. 16 How long in U. S., if foreign birth? 46 yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Roger Brooke Hopkins

6 DATE OF BIRTH (month, day, and year) Aug. 5, 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) San Domingo. West Indies.

PARENTS

10 NAME OF FATHER Allen Howard Crosby

11 BIRTHPLACE OF FATHER (city or town) New York (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Josepha McDonald Young

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country) N. Y.

14 Informant Mrs. Margaret Mitchell (Address) Summit & Pleasant 2.16

Filed ..... 19 ..... C. WALTER JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1930, to Feb. 6, 1930, that I last saw her alive on Feb. 6, 1930 and that death occurred, on the date stated above, at 8:57 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism
(post Operative)
1 hr. 12 min
(duration) ✓ yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) ✓
(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes. Date of Jan. 23, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schork, M. D.

2/6/1930 (Address) Homan's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friends Cem

DATE OF BURIAL Feb 8 1930

20 UNDERTAKER Hess Hankin & Co

ADDRESS Cre Mt Olivet

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53802

CERTIFICATE OF DEATH

3/ E 53802

1—PLACE OF DEATH Baltimore City Hospitals (TB.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 17-27 (Add.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence Neal

(a) RESIDENCE NO. 1315 Upton st. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Clarence Neal

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 1930, 19 ... JONES, M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1930, to Feb. 5, 1930,

that I last saw h.. im alive on Feb. 5, 1930

and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Thomas Jr., M. D.

2-5-, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2/7 1930
20 UNDERTAKER	ADDRESS
Daniel Hennessy	1 N Bond

Spec.—1-30—M. & T.—250 Blks.

E 53803

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53803

CERTIFICATE OF DEATH.

90

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 S. Madeira ST., 12 WARD)

2-FULL NAME John Boost.

(a) RESIDENCE NO. 310 S. Madeira ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (illegible) Anna Boost.

6 DATE OF BIRTH (month, day, and year) May 2nd 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joachim Boost.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cecelia Hell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Boost Wife
(Address) 310 S. Madeira A. 1

15 Filed (illegible) 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. , 1930, to Feb. 5 , 1930, that I last saw h[illegible] alive on Feb. 5 , 1930, and that death occurred, on the date stated above, at 10 40 a. m.

The CAUSE OF DEATH* was as follows:

Chs. Hypertension Arteriosclerosis

Chs. Myocarditis

?
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? residence.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isaac Feinglos, M. D.

2/7. 1930 (Address) 2007 E. Baltr St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Feb. 8th 1930

20 UNDERTAKER Lilly & Geiser

ADDRESS 403 S. Wolfe St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53804 ✓

CERTIFICATE OF DEATH

× 182

E 53804

1-PLACE OF DEATH

City of Baltimore: (No. Curtis Bay near Pennington Ave 25-77 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John A. Johnson.

(a) RESIDENCE NO. 430 Palos Verdis St. St. Pedro. Calif. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman on
(b) General nature of industry, business, or establishment in which employed (or employer) S/S Betterton.
(c) Name of employer

9 BIRTHPLACE (city or town) Norway.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Capt. John. Kvistberg.
(Address) S/S Betterton, Iowa, [illegible]

15 Filed [illegible] 1930 C. H. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 4, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Occidental fall from a boat.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What lesions confirmed diagnosis? Inquiry

(Signed) Otto E. Leinhardt, M. D.

2/7, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem.

DATE OF BURIAL Feb 7 1930

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

FEB 7 - 1930

Be sure DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53805

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53805

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 754 Reservoir ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Curran Hilberg

(a) RESIDENCE NO. 754 Reservoir ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred R Hilberg

6 DATE OF BIRTH (month, day, and year) Aug 25 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Curran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Hester

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Maria Barbara Mayer
(Address) 754 Reservoir St

15 Filed 7 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6-30

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Feb. 6, 1930, that I last saw h[illegible] alive on Feb. 5, 1930 and that death occurred, on the date stated above, at 9. P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Chronic nephritis (duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) Thos Bowman Hood, M. D.

2/7/1930 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rest Eastern Cem

DATE OF BURIAL Feby 8 1930

20 UNDERTAKER John O Mitchell and Sons

ADDRESS 1901 Eastern Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53806

CERTIFICATE OF DEATH

40 E 53806

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 N. Belnord ave ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Hauner

(a) RESIDENCE NO. 702 N. Belnord ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Hauner

6 DATE OF BIRTH (month, day, and year) Sept 15-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Trazler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Valter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Frank J. Hauner

(Address) 211 N. Monford ave

15 Filed Feb 7 1930 Registrar

MEDICAL CERTIFICATE OF DEATH Feb. 5-1930

16 DATE OF DEATH (month, day, and year) 2-5-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1930 to Feb 5 1930

that I last saw him alive on Feb 4 1930

and that death occurred, on the date stated above, at 9 10 a.m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) 1 yrs. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M.D.

19 (Address) 800 N. Wolfe St

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Feb 8 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager st

Spec.—8-16-29—L. F. S.—100 Bks.

E 53807

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53807

CERTIFICATE OF DEATH

77

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 N. Broadway ST., 7-13 WARD)

2—FULL NAME Minnie Beigel

(a) RESIDENCE NO. 920 N. Broadway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Beigel

6 DATE OF BIRTH (month, day, and year) March 1-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry E. Deline

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not known

14 Informant Mrs. Edna Criss
(Address) 920 N. Broadway

15 FEB 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5-1930

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to Feb 5, 1930, that I last saw h[illegible] alive on Feb 4, 1930 and that death occurred, on the date stated above, at 6.50 a. m.

The CAUSE OF DEATH* was as follows:

Ephendrin

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Insanity

Homicidal Frenzy (duration) 18 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Stanley L. Kittoleista, M. D.

2-6, 1930 (Address) 1038 N Broadway St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feb 8 1930

ADDRESS 1737 E. Baltimore St

20 UNDERTAKER George W. Zickler

Spec.—8-16-29—L. F. S.—100 Bks.

E 53808 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53808

CERTIFICATE OF DEATH

129

REGISTERED NO. 76-27

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3418 O'Donnell ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Berkemeier

(a) RESIDENCE NO. 3418 O'Donnell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Berkemeier

6 DATE OF BIRTH (month, day, and year) Nov 12-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Rhde

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Mrs. Bachman

(Address) 3418 O'Donnell St.

15 Filed 2/7/30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 1st, 1929, to Feb 6, 1930, that I last saw h[illegible] alive on Feb 6, 1930, and that death occurred, on the date stated above, at 9 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Paralysis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Endarteritis Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

2/7, 1930 (Address) 830 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Feb. 10 1930

20 UNDERTAKER George W. Zibler

ADDRESS 1737 E. Eager St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53809

74-001

CERTIFICATE OF DEATH

REGISTERED NO. E 53809

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3010 Northern Parkway ST. 27-43 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Lower

(a) RESIDENCE NO. 3010 Northern Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Lower

6 DATE OF BIRTH (month, day, and year) Oct. 14-1854.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	22 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Lewis Lower

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Hall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Mrs. Catherine Vance

(Address) 3010 Northern Parkway

15 Filed FEB 7 - 1930 By C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5- 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930, to Feb 5, 1930, that I last saw h alive on Feb 5, 1930, and that death occurred, on the date stated above, at 2.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Coronary Thrombosis, Cataract, Senilis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claud Bruns, M. D.

Feb 5, 1930 (Address) 47 W Hamilton Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park Cemetary

DATE OF BURIAL Feb. 8 1930

20 UNDERTAKER George W. Zirkle

ADDRESS 1737 E Eager

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53810

CERTIFICATE OF DEATH

90 E 53810

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 N Highw ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie Jewell

(a) RESIDENCE NO. 427 N Highw ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John Jewell

6 DATE OF BIRTH (month, day, and year) apprx 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
apprx 41	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) VW

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rev. Wilkerson

(Address) 1119 N Carrollton Ave

15 Filed FEB 7 - 1930 Registrar E. S. THOMPSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Feb 5, 1930, that I last saw h[illegible] alive on Feb 5 1930 and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Generalized Anasarca

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. J. Gourley, M. D.

Feb 7, 1930 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL Feb 8 1930

20 UNDERTAKER Robert F. Wallace

ADDRESS 1515 Mc Elderry Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53811

REGISTERED NO. E 53811

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 930 Mason St., 11-24 Ward)

2-FULL NAME Rebecca Henderson

(a) RESIDENCE NO. 930 Mason St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (Write the word)
Fem	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	about 80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) 041
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant A Neighbor
(Address)

15 Filed ... 19... C. HAMPSON JONES, M. D.
By Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Jan 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ...(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) 2 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) 2 yrs. 1 mos. ... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Blunk, M. D.

Feb 1 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL FEB 7 1930 19

20 UNDERTAKER Commissioner Health.

ADDRESS

1930 4334 MORGUE

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53812

E 53812

CERTIFICATE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals St., 76-37 Ward)

2-FULL NAME Jos Boone

(a) RESIDENCE NO. House of Correction St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	B	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) 087 Unknown
(c) Name of employer

9 BIRTHPLACE (city or town) —
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant
(Address) UNIVERSITY OF MARYLAND

15 Filed ..., 19... C. HAMPSON JONES, M. D.
Registrar

1943 Bx
THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Dockell Compensation

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What tests confirmed diagnosis? —

(Signed) J. C. Hampson Jones, M. D.

, 19 (Address) 1430 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL FEB 7 - 1930 19

20 UNDERTAKER

ADDRESS

Commissioner Health

Reg. No. E. WOODAL

Or. of DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53813

CERTIFICATE OF DEATH

E 53813

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 10-27 Ward)

2-FULL NAME Iona Nicholes

(a) RESIDENCE NO. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
55 ?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

FEB 7 - 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 10 1930

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. C. Grades, M. D.

, 19 (Address) 1436 Berry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL FEB 7 - 1930 19

UNIVERSITY OF MARYLAND

20. UNDERTAKER Commissioner Health

ADDRESS

James B. Cupit 1341 E. Lexington St

C. MARTSON JONES, M.D. Registrar

1341 THE MORGUE.

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very of death in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53814

REGISTERED NO. 18 E 53814

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 53814

1-PLACE OF DEATH

City of Baltimore: (No. East Falls Ave St. 3-5 Ward)

2-FULL NAME Unknown

(a) RESIDENCE NO. " St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	65?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed 19 Registrar

4340

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 19

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry find that said deceased came to No death
(Inquest, autopsy or inquiry)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning Acc?

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Examination

What test confirmed diagnosis?

(Signed) H. C. Blades, M. D.

19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL FEB 7 - 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

FEB 7 1930 C. MASON JONES, M.D.

BY THE CORONER

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53815

CERTIFICATE OF DEATH

E 53815

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 122 East St. St. 5-8 Ward)

2-FULL NAME Bernard Ewing

(a) RESIDENCE NO. 122 East St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	46	11 mos		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) 0
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..., 19.. C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan. 28-30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis

Four days.

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY
(Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) ..., M. D.

Feb. 1931 (Address) 1659 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY	19
20 UNDERTAKER Commissioner Health	ADDRESS

FEB 7 1930

FILED IN THE MORGUE

Be sure to print forms, so that it may be properly classified. Read statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53816

38 E 53816

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Eutaw Sts. WARD) 6-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Calvin Giles

(a) RESIDENCE NO. 802 N. Mount St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30th

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Richard Giles

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Cambridge Maryland

12 MAIDEN NAME OF MOTHER Elsie Johnson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Elsie Johnson (mother)

(Address) 802 N Mount St

Filed FEB 7 1930, C. HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 19 30 to Feb 5, 19 30,

that I last saw him alive on Feb 5, 19 30

and that death occurred, on the date stated above, at 11:40 A m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 6 mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) M B Schneider, M. D.

, 19 (Address) 7 Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY	19

20 UNDERTAKER P.D.

ADDRESS Commissioner Health FEB 6 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53817

7/4-001 E 53817

CERTIFICATE OF DEATH

E 53817

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

City of Baltimore: (No. St. Agnes Hospital St., 20-10 Ward)

2-FULL NAME Michael McNamara

(a) RESIDENCE NO. 41 Manley Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer) St Mary's Industrial School
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Patrick McNamara

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora McNamara

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Patrick McNamara
(Address) 1223 Vath

15 Filed 19 C. HARRISON JONES Registrar

FEB 7 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:*

a Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas W Brooke M. D.

Feb 7 1930 (Address) 3601 3-16

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Feb 8, 1930

20 UNDERTAKER D. Rita Windfield — ADDRESS 914 Gunman Ave

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53818

CERTIFICATE OF DEATH

129

E 53818

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel T. Pearcy

(a) RESIDENCE NO. 1400 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	2 8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inmate of Aged Women's Home

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary Land

PARENTS

10 NAME OF FATHER Jacob Pearcy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Trocker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Supt. Aged Women's Home

(Address)

15 [illegible] 7 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1930, to Feb 6, 1930, that I last saw h. im alive on Feb 6, 1930 and that death occurred, on the date stated above, at 3 25 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia, pulmonary oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry

(Signed) Richard T. Shuck ford, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 8 1930
20 UNDERTAKER George E. Smith	ADDRESS 153 Hollins St

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53819

CERTIFICATE OF DEATH

17 VE 53819

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 27-47 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Kramer.

(a) RESIDENCE NO. 4827 York Rd. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3
February 6, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER George Kramer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Marie Huppner.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant William Kramer. (brother)
(Address) 4827 York Rd.

15 Filed 2-7-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 7, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the 1st. Lumbar Vertebrae with severance of the Cord. Jumped from Hanover St. Bridge. Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hanover St. Bridge
February 3rd. 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Eisenhardt, M. D.

2/7, 1930 (Address) 107 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb. 8, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balt. St.

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53820

CERTIFICATE OF DEATH

90 E 53820

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4135 Great Park Ave. ST., WARD)

2—FULL NAME Sadie J. Brown

(a) RESIDENCE NO. 4135 Great Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

6 If married, widowed, or divorced (or) WIFE of Charles E Brown

6 DATE OF BIRTH (month, day, and year) Nov 8-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57 58		2	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Maryland

PARENTS

10 NAME OF FATHER Wm H. Hartzell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Amanda Eveland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Maryland

14 Informant Mrs. Fannie V. McCubbin

(Address) 1709 E. Federal St

15 Filed 7 - 1930 C. HAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 5-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17- 1930 to Febry. 5- 1930

that I last saw h alive on Febry. 5- 1930

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Lowell Brown, M. D.

2/5. 1930 (Address) 1663 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery

DATE OF BURIAL Feb. 8 1930

20 UNDERTAKER Henry Fanning Sons

ADDRESS Edgewood md

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53821

90 E 53821

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 227 N Spring St. 3-4 Ward)

2-FULL NAME Florence Reddick

(a) RESIDENCE NO. 253 N Spring St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	C.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Reddick

6 DATE OF BIRTH (month, day, and year) 1 | 3 | 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(r) Name of employrr

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Anna Reddick
(Address) 253 N. Spring St

15 Filed - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 6 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? By Clinical Findings

(Signed) G. E. Lander, M. D.

19 (Address) 438 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedarcroft Cemetery — DATE OF BURIAL 2/7 1930

20 UNDERTAKER George J Ruth — ADDRESS 1735 Hanford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53822

CERTIFICATE OF DEATH

90 E 53822

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Enroute

City of Baltimore: (No.) Sinai Hospital St. 15-64 Ward)

2-FULL NAME Leopold Wertheim

(a) RESIDENCE NO. 3917 Maine Ave St., Ward

(Usual place of abode) 38 (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Etta Wertheim

6 DATE OF BIRTH (month, day, and year): July 11/1875

7 AGE: Years 54 | Months 6 | Days 26 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Haberdasher
(b) General nature of industry, business, or establishment in which employed (or employer): (Self)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Burglein, Germany

PARENTS

10 NAME OF FATHER: Jacob Wertheim

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Nannie Katz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Germany

14 Informant: Sol. Wertheim
(Address): 3917 Maine Ave

15 Filed: 2-7-1930 G. HARRISON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Disease Rheumatic Cardiac-Valvular (duration) ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History given

(Signed) J. H. Collins, M. D.

2/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Hebrew Cemetery

DATE OF BURIAL: 2/9/ 19 3

20 UNDERTAKER: J. Ahearn & Co

ADDRESS: 2432 Eastern Ave

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

(Clifford Marvel) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53823

E 53823

CERTIFICATE OF DEATH

× 38

1—PLACE OF DEATH University Hospital

REGISTERED NO. 4-30

CITY OF BALTIMORE: (No. Saraband + Green ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clifford L. Marvel

(a) RESIDENCE NO. Woodlawn, Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Albert T. Marvel

11 BIRTHPLACE OF FATHER (city or town) Phila
(State or country)

12 MAIDEN NAME OF MOTHER Leonia Stoll

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mr. Marvel.
(Address) Woodlawn Md

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 30, to Feb. 6, 19 30

that I last saw h. alive on Feb. 6, 19 30

and that death occurred, on the date stated above, at 6 15 p.m.

The CAUSE OF DEATH* was as follows:

~~Congenital Lues~~

Broncho pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY
(Secondary) Congenital Lues (duration) ... yrs. 6 mos. 20 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter S. Johnson M. D.

Feb. 19 30 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL 2/8 1930

20 UNDERTAKER L. F. McCully

ADDRESS 130 E. Front

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53824

CERTIFICATE OF DEATH

31 E 53824

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (TB) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10-14 ST. WARD)

2—FULL NAME William J. Comfort

(a) RESIDENCE NO. 945 Ensor st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Wm. J. Comfort

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Mary Hodges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Hospital Records

(Address)

Filed 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1930, to Feb. 7, 1930, that I last saw h im alive on Feb. 7, 1930, and that death occurred, an the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jno. Thwaites, M. D.

2-7-, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 2/10 1930

20 UNDERTAKER Mary A. Gawthrop — ADDRESS 2839 Rayner

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53825

CERTIFICATE OF DEATH

90 E 53825

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 300 E University Pkwy (St.) (Ward)

2—FULL NAME Elizabeth Ann Fick

(a) RESIDENCE NO. 380 E University Pkwy ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single, Married~~, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Fick

6 DATE OF BIRTH (month, day, and year) Jan 21-1851

7 AGE Years 79 Months - Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER James Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Edward Fick

(Address) 300 E University Pkwy

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1930, to Feb 6, 1930, that I last saw her alive on Feb 6, 1930 and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Myocarditis
Arterio-sclerosis.
Cystitis.
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) W H Woodall, M. D.

, 19 (Address) 140 S Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemt — DATE OF BURIAL Feb 10th 1930

20 UNDERTAKER Kaufman & Fore — ADDRESS 1723 W Lafayette Ave

37 1930

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53826

CERTIFICATE OF DEATH.

E 53826

1-PLACE OF DEATH St. agnes Hospital

CITY OF BALTIMORE: (NO. 25-72 ST. (OR WARD) 101

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr John T Goodwin John T. Goodwin

(a) RESIDENCE NO. 3607 Hireline Road ST., ... WARD St. Ams
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Mr. John~~ Nannie Goodwin

6 DATE OF BIRTH (month, day, and year) Jan 17-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53.	0	21 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of Industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joshua Goodwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Frances Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Nannie Goodwin
(Address) 3607 Hireline Road

15 Filed Feb 8 1930 C. HAMPSON JONES, M. D. Registrar
By ....

B8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 .1930. to Feb 7 .1930.
that I last saw h in alive on Feb 7 .1930.
and that death occurred, on the date stated above, at 1:53 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Paul Phen ....., M. D.

2/7 .1930 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL Feb. 10, 1930

20 UNDERTAKER Wm J. Tickner & Sons — ADDRESS N. & Pa.

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53827 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53827

CERTIFICATE OF DEATH.

REGISTERED NO. 88

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1711 E. 33rd (ST.) 946 (WARD)

2-FULL NAME Katie Hardtner Braun

(a) RESIDENCE No. 1711 E. 33rd St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Braun

6 DATE OF BIRTH (month, day, and year) Aug 13, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John F. Hardtner

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Cinick

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mr. Ralph Braun

(Address) 1711 E. 33rd St.

15 Filed FEB 8 1930 C. MADISON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/29, 19 30, to 2/6, 19 30, that I last saw h[illegible] alive on 2/5, 19 30, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Ac

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. J. Braun, M. D.

2/7 19 30 (Address) 2439 11th E. Elden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL Feb. 8 19 30

20 UNDERTAKER Wm. Fickner Sons — ADDRESS North & Pa

Spec.—1-10 21—M&T—1500 Blks.

E 53828

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53828

CERTIFICATE OF DEATH.

16-27 89

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 N. Fulton Ave St., ... WARD)

2-FULL NAME Charles Edwin Turner

(a) RESIDENCE NO. 610 N. Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma N. Turner

6 DATE OF BIRTH (month, day, and year) June 9-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	61	7	28 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lulany Hennighy & Co Bagshi

9 BIRTHPLACE (city or town) ..... (State or country) L. I.

PARENTS

10 NAME OF FATHER Edwin Turner

11 BIRTHPLACE OF FATHER (city or town) Berkshere (State or country) England

12 MAIDEN NAME OF MOTHER Mary E. Akis

13 BIRTHPLACE OF MOTHER (city or town) Brooklyn (State or country) N. Y.

14 Informant Mrs Emma N. Turner
(Address) 610 N. Fulton Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from January 17th, 1929, to Feb 6th, 1930, that I last saw him alive on Feb 6th, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 yrs. mos 20 da.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. D. Hammett, M. D.

Feb 7, 1930 (Address) 1989 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb 10 1930

UNDERTAKER Wm J Tuckner & Son

ADDRESS N. & Pa

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53829

CERTIFICATE OF DEATH

1929

E 53829

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) University Hospital 22-30 St., (Ward)

2-FULL NAME Zilphia Campbell

(a) RESIDENCE NO. 535 W. Lee St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 037

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER George Gray

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Geo. Turner
(Address) 535 W. Lee St

15 Filed FEB 8 - 1930 16 C. HUGH JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Augusta Tolley, M. D.

2/7. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 2-8 1929

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Druid Hill

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53830

CERTIFICATE OF DEATH.

E 53830

1-PLACE OF DEATH West Balto General Hospital

CITY OF BALTIMORE: (No. Baltimore, Md. ST. 20-69 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie L. Matthews

(a) RESIDENCE NO. 2132 W. Mulberry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Matthews

6 DATE OF BIRTH (month, day, and year) June 2. 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Douglass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Alice Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Matthews
(Address) 2132 Mulberry St

Filed 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 27, 1930, to Feb 7, 1930, that I last saw her alive on February 7, 1930 and that death occurred, on the date stated above, at 8 a m

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. H. Custer, M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 2/10 1930

20 UNDERTAKER McCoh

ADDRESS 247 Hanover St.

FOR IMPORTANT INSTRUCTIONS SEE REVERSE OF CERTIFICATE.

Spec.—2-19-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53831 — REGISTERED NO. — E 53831

1—PLACE OF DEATH Hospital for the Women of Maryland

CITY OF BALTIMORE: (No. Maryland and Linden ST., 9246 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Josephine Foreman

(a) RESIDENCE NO. 1503 Linwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Foreman

6 DATE OF BIRTH (month, day, and year) June 1, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Howard County
(State or country) Md

PARENTS

10 NAME OF FATHER Howard Buckingham

11 BIRTHPLACE OF FATHER (city or town) Howard County
(State or country)

12 MAIDEN NAME OF MOTHER Rachel Condon

13 BIRTHPLACE OF MOTHER (city or town) Howard County
(State or country)

14 Informant Herbert Wells Butler
(Address) 1701 East Street

15 Filed FEB 8 - 1930, 19 C. RAYMOND JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 - 1930

17 I HEREBY CERTIFY, That I attended deceased from December 17, 1929, to February 7, 1930,

that I last saw her alive on February 7, 1930,

and that death occurred, on the date stated above, at 7:45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovaries

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Terminal (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. G. Lynn III, M. D.

, 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet, Mt Airy Md	2/9 1930

20 UNDERTAKER Wm Cook ADDRESS 217 E Saratoga St

Spec.—1-30—M. & T.—250

E 53832 HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Wiley
Math Ave
6-2
40

~~B~~ 53832

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 Mura ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Hunt

(a) RESIDENCE NO. 2121 Mura ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Hunt

6 DATE OF BIRTH (month, day, and year) Jan 3, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) — 030

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wiley Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Anna M. Hunt (Address) 2121 Mura St

15 Filed 8-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6, 1930

17 I HEREBY CERTIFY That I attended deceased from July 20, 1929 to Feb 6, 1930 that I last saw h[illegible] alive on Feb 6, 1930 and that death occurred, on the date stated above, at 3a. m.

The CAUSE OF DEATH was as follows:

Chronic Prostatitis - Vesicle -
Necrosis of Hunt

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W J Gray M. D.

2/7/30 (Address) 6711 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Feb 8 1930

20 UNDERTAKER Wm Cook — ADDRESS 1207 N Paca

Spec.—8-16-29—1,000—20 Blks.

E 53833

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53833

CERTIFICATE OF DEATH

REGISTERED NO. 67-00

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3722 Buchler Ave (ST.) 47-56 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Miller

(a) RESIDENCE NO. 3722 Buchler Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah R Miller

6 DATE OF BIRTH (month, day, and year): Oct 23, 1852

7 AGE: Years 77 | Months 3 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Decorator

(b) General nature of industry, business, or establishment in which employed (or employer): Self 53

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frankford N. Y.

PARENTS

10 NAME OF FATHER: Frederick Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sarah R Miller

(Address) 3722 Buchler Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6. 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to Feb 6, 1930, that I last saw him alive on Feb 6 at, 1930 and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Prostatitis Cystitis, Uremia, Nephritis, Myocarditis

(duration) 11 yrs. 2 mos. 8? da.

CONTRIBUTORY (Secondary): Painters Colic

Don't Know (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no, Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical & Chemical & Physical

(Signed) Llewellyn M Dyker, M. D.

Feb 7. 1930 (Address) 5400 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 2/8 19 30

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53834

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53834

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 James ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Calista J. Conklin

(a) RESIDENCE NO. 1202 James ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Calvin F. Conklin

6 DATE OF BIRTH (month, day, and year) Aug 9. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Luther Shriver

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Louse

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mrs Emma Conklin

(Address) 1202 James St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 18. 1930 to Feb 7 1930

that I last saw h alive on Feb 7 1930

and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(daration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Hemiplegia

(daration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theo. Dram M. D.

2-7 1930 (Address) 727 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkview Ne New York

DATE OF BURIAL 2/8 1930

20 UNDERTAKER W. Cook

ADDRESS 1217 E Paul St

Spec.—1-30—M. & T.—250 Blks.

E 53835 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53835

CERTIFICATE OF DEATH.

REGISTERED NO. 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 N. Arlington Ave ST. E-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Hawkins

(a) RESIDENCE NO. 216 N. Arlington Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 5 mos. 18 da. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Hawkins

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. Hawkins

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Ella Gardner

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Florence Hawkins
(Address) 216 N. Arlington Ave.

Filed 2-8-1930 C. HAMPSON JONES, M. D. Registrar

By E.A.V.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-30

17 I HEREBY CERTIFY, That I attended deceased from January 5, 1930, to Feb 6, 1930, that I last saw him alive on Feb 6, 1930, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) ..... yrs. 5 mos ..... da.

CONTRIBUTORY (Secondary) General Carcinosis

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical - X-ray

(Signed) R. Maw Williams, M. D.

2-7 1930 (Address) 830 Madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. National Cemetery

DATE OF BURIAL Feb 9, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

Spec.—1-12-23—M&T—500 Bks.

Time of arrival extended to Feb 9, 20 J. Frederick Tempe asst. Coro

E 53836 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53836
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 Druid Hill Ave St. 11-59 WARD)

2-FULL NAME Richard Henry Spriggs

(a) RESIDENCE NO. 214 Druid Hill Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia Spriggs

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Elizabeth Booker
(Address) 245 Pamela Ave

15 Filed FEB 8 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 4 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/26, 1930, to 2/4, 1930, that I last saw h[illegible] alive on 2/4, 1930, and that death occurred, on the date stated above, at 11:55 P m.

The CAUSE OF DEATH* was as follows:

Cl. Nephritis + Uremic Poisoning

Uremia 8

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ben Roberts, M. D.

2/6, 1930 (Address) 4 W Dix - C

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery

DATE OF BURIAL Feb. 9, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 324 N. Schroeder St.

FOR IS VERY important See instructions on back of Certificate.

8 - 1930

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53837

E 53837

CERTIFICATE OF DEATH.

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1435 Parrish St. 15-21 (WARD)

2-FULL NAME Eva Bartlett

(a) RESIDENCE NO. 1435 Parrish St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Bartlett

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thos Bartlett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Matilda Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Richard Bartlett

(Address) 1435 Parrish St

15 Filed FEB 8 - 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Feb 6, 1930,

that I last saw her alive on Feb 6, 1930,

and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Duration yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. O. Fletcher, M. D.

Feb 7, 1930 (Address) 3100 Parrish St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carson Va.

DATE OF BURIAL 2-9 1930

20 UNDERTAKER Samuel Corbett

ADDRESS Va

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53838

CERTIFICATE OF DEATH

24 E 53838

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

2—FULL NAME Augustus Turner

(a) RESIDENCE NO. 1413 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or estabiishment in which employed (or employer) School

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Hamlet, N.C.

PARENTS

10 NAME OF FATHER Augustus Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Annie Ingram

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Augustus Turner
(Address) 1413 Brunt St

15 Filed 1930 By C. HENDON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 7, 1930, that I last saw him alive on Feb 6, 1930 and that death occurred, on the date stated above, at 6 20 a.m.

The CAUSE OF DEATH* was as follows:

Meningitis (Meningococcic)

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 1413 Brunt St -

Did an operation precede death? No Date of —

Was there an autopsy? No Spinal

What test confirmed diagnosis? Clinical findings & puncture

(Signed) Addison Craft Dilley, M. D.

2-7. 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W.M.C. Andrews

DATE OF BURIAL Feb. 8 1930

20 UNDERTAKER D. Sam C. H. Evans Sons

ADDRESS 40 Hanover

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53839

E 53839

111-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 N. Carrollton Ave ST.: 18-26 WARD)

2-FULL NAME Julia Byrd

(a) RESIDENCE. No. 514 N. Carrollton Ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Byrd

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Charles Bowles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Hunter (Address) 514 N. Carrollton

15 Filed 1930 C. HALLECK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1930

17 I HEREBY CERTIFY, That I attended deceased from June 31, 1930, to Feb 6, 1930, that I last saw h[illegible] alive on Feb 5, 1930, and that death occurred, on the date stated above, at 3 p m.

The CAUSE OF DEATH was as follows:

Gastric Ulcer

(duration) One Year

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

19 (Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	2/8 1930
20 UNDERTAKER Thomas E. Kelam	ADDRESS 1303 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

8-1930

Spec.—2-29-28—L. P. S.—500 Blks.

E 53840

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-001

E 53840

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Mc Henry St. 58-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lavine Hicks

(a) RESIDENCE NO. 1111 Mc Henry ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hicks

6 DATE OF BIRTH (month, day, and year) June 8, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) At Home 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Keysville Va

PARENTS

10 NAME OF FATHER Reid Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Staples

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant George Hicks

(Address) 1111 Mc Henry St

15 Filed FEB 8 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6-30

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1930, to July 6, 1930

that I last saw her alive on July 16, 1930

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary) Anorexia & Low Vitality

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical

(Signed) E. H. Wallis, M. D.

, 19 (Address) 4438 St George Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Keysville Va

DATE OF BURIAL Aug 8 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1725 Ashland Ave

Important: See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 53841

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53841

CERTIFICATE OF DEATH.

100,001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 N. Dallas ST. 8-17 WARD)

2-FULL NAME Edward Somerville Jr.

(a) RESIDENCE NO. 1510 N. Dallas ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-23-26

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	3	1	14 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Somerville

11 BIRTHPLACE OF FATHER (city or town) Macon N.C.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Crew Ga.
(State or country)

14 Informant Thos. Somerville
(Address) 1510 N. Dallas St.

15 Filed ..... 19 ... By ..... Registrar

8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.6.1930

17 I HEREBY CERTIFY, That I attended deceased from 2.5., 1930, to 2.6., 1930, that I last saw h. alive on 2.6., 1930, and that death occurred, on the date stated above, at 1:20 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Wm. L. Roy Berry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dnt. Cabany — DATE OF BURIAL Feb. 8 1930

20 UNDERTAKER Mrs. R. G. Elbert. — ADDRESS 1725 Ashland Ave

TION is very important. See instructions on back of certificates.

Spec.—3-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53842 | CERTIFICATE OF DEATH. | 90 VE 53842

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 N Read St.; 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Salvador Giglio

(Residence in Baltimore: No. 315 N Read St. St.; 72 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): widower

6-DATE OF BIRTH: 12 (Month) 24 (Day), 1863 (Year)

7-AGE: 66 yrs. 1 mos. 14 ds. If LESS than 1 day, 13 hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Italy

PARENTS.

10-NAME OF FATHER: Phillip Giglio

11-BIRTHPLACE OF FATHER (State or Country): Italy

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. Giglio

(Address) 315 N. Read Street

C. MARSHALL JONES, M. D.

15- File ES8-1934 19[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 2 (Month) 7 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 2/2, 1930, to 2/6, 1930, that I saw h[illegible] alive on 2/6, 1930, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows: Carcinoma Primary

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia Pulmonis Carcinoma

(Duration) Unknown yrs. mos. ds.

(Signed) Lorenzo Dow M. D.

2/8, 1930 (Address) 2701 E Monument St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cemetery

DATE OF BURIAL, 2-10, 1930

20-UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 53843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 ✓E 53843

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2730 Riggs av ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma B. Hahn

(a) RESIDENCE NO. 2730 Riggs av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
F	White	Singe

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 20. 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Louis Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Shirey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Daisy M. Kennedy

(Address) 2730 Riggs av

15 Filed 1930 C. HAUGH JONES, M.D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7/30

17 I HEREBY CERTIFY, That I attended deceased from 1/11 1930 to 2-7 1930

that I last saw her alive on Feb 7 1930

and that death occurred, on the date stated above, at 10.15 P.M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

Diabetes (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of 3 yrs ago Amputation of leg

Was there an autopsy?

What test confirmed diagnosis? Blood Sugar Test

(Signed) C. Haugh Jones, M. D.

19 (Address) 812 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemy.

DATE OF BURIAL Feb 10 1930

20 UNDERTAKER Lyons & Ruth

ADDRESS 1735 Harford av.

IMPORTANT.—SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53844

REGISTERED NO. 90 E 53844

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Russell & Fremont Ave. St. 21-29 Ward)

2-FULL NAME Anna E Taylor.

(a) RESIDENCE NO. 1222 N. Ostend St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 9 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced (or) WIFE of William E. Taylor.

6 DATE OF BIRTH (month, day, and year) May -- 1873

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	9	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER David Seamore.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Anna L. Hann.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant William E. Taylor. (husband)
(Address) 1222 N. Ostend St.

15 Filed 19 C. HILLEN JONES
Registrar

B 8 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

2/7, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb 10 1930

20 UNDERTAKER John J. Field

ADDRESS 120 N. Howard

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53845

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53845

CERTIFICATE OF DEATH

38 V

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Lendenhall St., 7-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Pintney

(a) RESIDENCE NO. 907 Lendenhall ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alex Pintney

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thos. Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Potter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rosie Pintney
(Address) 907 Lendenhall

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/6/30

17 I HEREBY CERTIFY, That I attended deceased from 1/23/30, to 2/6/30, 1930,
that I last saw ... alive on 2/6, 1930,
and that death occurred, on the date stated above, at 11.03 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

14 (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Uremia Poisoning (duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Jm Crowley, M. D.

2/7, 1930 (Address) 1708 Eshaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct

DATE OF BURIAL Feb 9 1930

UNDERTAKER J. E. Brown & Son

ADDRESS 1011 W. Mont St

Spec.—2-29-28—L. F. S.—500 Blks.

E 53846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-001
37 E 53846

1—PLACE OF DEATH Baltimore City Hospitals (Bon 5-8)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2—FULL NAME Samuel Jackson

(a) RESIDENCE NO. 145 Colvin st. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Jackson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Priscilla ?

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Hospital Records

(Address) .....

15 Filed ..... 19 ..... C. H. Harrison Jones, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1930, to Feb. 5, 1930,

that I last saw him alive on Feb. 5, 1930

and that death occurred, on the date stated above, at 9.26 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Jas Gherardi M. D.

2-6-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 2-8-1930

20 UNDERTAKER Byron & Knight

ADDRESS 1218 McElderry St

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53847 — REGISTERED NO. E 53847

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2303 Ruskin Ave ST. 15-6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas A. Fahey

(a) RESIDENCE NO. 2303 Ruskin ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Kelly Fahey

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56	55	11	28 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet metal worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 084

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Patrick Fahey

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Margaret Baldwin

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Thomas B. Fahey

(Address) 2303 Ruskin Ave.

15 Filed ..... 19 ..... C. EDGAR JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1930, to ....., 19....., that I last saw him alive on Feb. 7, 1930, and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. A. Simmonds, M. D.

, 19 (Address) 306 N. Greene St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Feb. 10, 1930.

20 UNDERTAKER Martin Fahey & Sons — ADDRESS 1827 W North Ave

FEB 10 1930

Spec.—2-29-28—L. F. S.—500 Blks.

E 53848

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53848

CERTIFICATE OF DEATH

REGISTERED NO. 15-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2139 N. Pulaski ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary D. Feaney

(a) RESIDENCE NO. 2139 N. Pulaski ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Edward Feaney

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER J. Miller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Edward Feaney
(Address) 2139 N. Pulaski St.

15 Filed ....., 19.... C. HARRISON JONES, M.D.
Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 7, 1930, that I last saw h[illegible] alive on Feb 7, 1930 and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

(duration) X yrs. X mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Edw Talbot, M. D.

, 19 (Address) 1355 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Feb. 8, 1930

20 UNDERTAKER Martin Fahey & Sons — ADDRESS 1827 W. North Ave

Important: See instructions on back of certificate.

8 - 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53849

E 53849

CERTIFICATE OF DEATH

99-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 224 S. Duncan St., 2-4 Ward)

2-FULL NAME Dr. Louis O'Donnell

(a) RESIDENCE NO. 224 S. Duncan St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12, 1924

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	6	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph O'Donnell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Anna Crist

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Joseph O'Donnell
(Address) 224 S. Duncan

15 Filed Feb 8, 1930 C. HAMPSON JONES, Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

AC Bronchitis

(duration) — yrs. — mos. 7 da.

CONTRIBUTORY (Secondary) Pt Lauderdale

(duration) — yrs. — mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there a autopsy? History

What test confirmed diagnosis?

(Signed) J C Slade, M. D.

, 19 (Address) 430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Feb 8 1930

20 UNDERTAKER Frank V. Pipitone

ADDRESS 2718 E. Balto st

8

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53850

CERTIFICATE OF DEATH

98 E 53850

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 17-24 Ward)

2-FULL NAME Wilmer Eugene Campbell

(a) RESIDENCE NO. 1327 Argyle Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	White Basic	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4 - 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	1	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employrr)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Wilmer Campbell

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Butler

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Wilmer Campbell
(Address) 1327 Argyle Ave

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laryngitis (Streptococcic?)

(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY
(Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Mitchell, M. D.

2/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2/8 1930
20 UNDERTAKER Samuel N. Housley	ADDRESS 578 Bdle

Spec. 8-15-29—L. F. S.—100 Bks.

E 53851

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53851

CERTIFICATE OF DEATH

122-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary WARD) 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mike Lorenzo

(a) RESIDENCE NO. Niagara Falls, Canada ST., " WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Canadian	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Lorenzo.

6 DATE OF BIRTH (month, day, and year) About 29 yrs

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Welder.

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada.

PARENTS

10 NAME OF FATHER Peter Lorenzo.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Rosa York

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Carmen) Lorenzo

(Address) 107 E Robert St. Balto Md

15 Filed May 19 [illegible] Registrar

8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1930, to February 6, 1930, that I last saw him alive on February 6, 1930 and that death occurred, on the date stated above, at 1:20 A. m.

The CAUSE OF DEATH* was as follows:

Portal cirrhosis; Liver abscess.

(Morphia addiction, one year.) 68

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia, pulmonary oedema (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? Yes Date of January 9, 1930

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Orin B. Wallace M. D.

, 19 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 2/6/30

20 UNDERTAKER J J Fahey & Son

ADDRESS 1318 Light St

Spec.—8-16-29—L. F. S.—100 Bks.

E 53852 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 53852

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse Gardner Jr

(a) RESIDENCE NO. 2029 Madison ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 27-28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	10	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particolar kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Jesse Gardner Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Helena Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jesse Gardner Jr. (Address) 2029 Madison Ave

15 Filed 8-1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to Feb 7, 1930, that I last saw h[illegible] alive on Feb 7 1930 and that death occurred, on the date stated above, at 0.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary) Ulcerative Coxphagitis

(duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical, Lab. autopsy

(Signed) Carroll M. St Clair, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 2/10/1930

20 UNDERTAKER Mrs. Leo H Hollan

ADDRESS 1631 Druid Hill

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53853

CERTIFICATE OF DEATH

E 53853

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miles Layton

(a) RESIDENCE NO. Bayard, West Virginia ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug-29-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	17	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at school.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bayard W Va

PARENTS

10 NAME OF FATHER Elgin Bayard.

11 BIRTHPLACE OF FATHER (city or town) Bayard W Va (State or country)

12 MAIDEN NAME OF MOTHER Sue Boering

13 BIRTHPLACE OF MOTHER (city or town) Bayard W Va (State or country)

14 Informant Elgin Layton

(Address) Bayard W Va

15 Filed 8 - 1930 C. H. Lawson Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 2, 1930, to February 7, 1930, that I last saw h.i.m. alive on February 7, 1930, and that death occurred, on the date stated above, at 5:55 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor.

(duration) yrs. 4 mos. da.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 3hrs.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of February 7, 1930.

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation and autopsy

(Signed) Richard G. Cobenz, M. D.

, 19 (Address) Talbot & Preston Sts. Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bayard, W.Va.

DATE OF BURIAL Feb 8 1930

20 UNDERTAKER Stephen Jones Sons Inc

ADDRESS 111 Broadway

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53854

CERTIFICATE OF DEATH

101-081 E 53854

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Enroute to Hopkins Hospital

City of Baltimore: (No. St., 7-9 Ward)

2-FULL NAME Bettie Jean Jenkins

(a) RESIDENCE NO. Government Reservation St. Indian Head Ward & Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18/29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Wash. D.C.

PARENTS

10 NAME OF FATHER David M. Jenkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Salisbury, Md.

12 MAIDEN NAME OF MOTHER Ada Banks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hebron, Md.

14 Informant David M. Jenkins (father)
(Address) Indian Head Md.

15 1930 C. [illegible] 19 Registrar

Sar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7/30 32

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL M.E. Church South Salisbury Md.

DATE OF BURIAL Feb 9/30

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53855

123 E 53855

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Church Home & Infirmary Ward) 7-17

2-FULL NAME Anna Stefan

(a) RESIDENCE NO. 717 N. Glover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced (a) HUSBAND of (or) WIFE of Joseph Stefan

6 DATE OF BIRTH (month, day, and year) March 20/1870

7 AGE 59	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria-Hungaria

PARENTS

10 NAME OF FATHER Joseph Klein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria-Hungaria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria-Hungaria

14 Informant Joseph Stefan, Jr
(Address) 717 N. Glover St

15 Filed 1930 C. RAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholangitis- Cholelithiasis

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of Feb 8/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Ellis Cocan, M. D.

2/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer. DATE OF BURIAL Feb 12 1930

20 UNDERTAKER Augus D. Pasek 2404 ADDRESS Ashland ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 53356

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53356

CERTIFICATE OF DEATH

38

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 17 W Hughes (ST.) 22 31 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Watkins

(a) RESIDENCE NO. 17 W Hughes ST., " " WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Watkins

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER William Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Lucy Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Oscar Watkins

(Address) 17 W. Hughes St

15 Filed 9-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/30

17 I HEREBY CERTIFY, That I attended deceased from 7/5/30, to 7/6/30

that I last saw her alive on 7/6/30

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sub acute Parenchymatous nephritis (Kidney Trouble) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Hampson Jones, M. D.

7/7/30 (Address) 1708 Shoy St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calary Cemtery

DATE OF BURIAL 7/9 1930

26 UNDERTAKER Walter B. Spriggs

ADDRESS 139 W. Hamburg St.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53857

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 53857

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Goldsborough

(a) RESIDENCE NO. 1114 E. Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life Unknown da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Sept. 13, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown -

(b) General nature of industry, business, or establishment in which employed (or employer) 687

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Goldsborough

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 9-1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7-30

17 I HEREBY CERTIFY, That I attended deceased from 2-5-30, 19..., to 2-7-30, 19...,

that I last saw h... alive on 2-7-30, 19...

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Acute

(daration) ...yrs. 6 mos. ...da.

CONTRIBUTORY (Secondary) Tonsillitis, Chronic Acute ?

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McKeen, M. D.

2-7, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Evergreen Cemetery

DATE OF BURIAL 2/10 1930

20 UNDERTAKER Mrs. Chas. G. Bailey

ADDRESS 1421 Jefferson St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53858

CERTIFICATE OF DEATH

31 E 53858

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 n Chapel ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Thiaton

(a) RESIDENCE NO. 423 n Chapel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Thiaton

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE 27	Years 26	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) va

PARENTS

10 NAME OF FATHER Arthur Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) va

12 MAIDEN NAME OF MOTHER Mary Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Carter

(Address) 1404 n Caroline

15 Filed 9-1930 C. H. Harrison Jones M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 5-'30

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929, to Feb 5, 1929, that I last saw h.. alive on Feb 3, 1930 and that death occurred, on the date stated above, at 3 40 am m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no ✓

What test confirmed diagnosis? Bacteriological

(Signed) J Edward Fisher, M. D.

2-5, 1930 (Address) 1612 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery — DATE OF BURIAL Feb 6 1930

20 UNDERTAKER E. Edward Bryan — ADDRESS 1681 orleans st

Spec. 1 10-31 MAT 1500 Blks.

E 53859

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53859

CERTIFICATE OF DEATH.

34

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) 27-55

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Robinowitz

(a) RESIDENCE NO. 3717 Glyndon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, (Married), Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Robinowitz

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 52; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery 034

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Harry Robinowitz

11 BIRTHPLACE OF FATHER (City or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Linkow

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Russia

14 Informant: Sarah Robinowitz (Address) 3717 Glyndon Ave

15 Mar. 1930 .19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/7 1930

17 I HEREBY CERTIFY, That I attended deceased from 12/6 .1929. to 2/7 .1930.

that I last saw him alive on 2/7 .1930.

and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

1 Pneumonia, miliary 2 Tuberculosis

(duration) yrs. 3 mos. 4 ds.

CONTRIBUTORY (Secondary): Pott's disease (TB of spine)

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Jan 12, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical & operation

(Signed) Benj Klotz M. D.

2/7. 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 2/9 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore

CAUSE OF DEATH IS TO BE STATED IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 53860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 53860

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Balser

(a) RESIDENCE NO. 917 E Lombard St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Roffel Balser

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 59 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address) 1439 E Baltimore St

15 Filed ... 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/8 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1930, to Feb 8, 1930.

that I last saw her alive on Feb 8, 1930,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Aneurysm of the aorta

Unknown (duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) to Syphilis of vascular System

Unknown (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. A. Schultz M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodeph Shom

DATE OF BURIAL: 2/9 19

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore St

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53361

E 53361

Surg

100.001

CERTIFICATE OF DEATH

REGISTERED NO. _____

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 40-13 WARD)

2—FULL NAME George Stine

(a) RESIDENCE NO. 1462 Eager St ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12/25/60

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) J. H. H. 062

(c) Name of employer John Onnen

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed _____, 19 C. HAMPSON JONES, M. D. Registrar

Rec'd

3-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-30

17 I HEREBY CERTIFY, That I attended deceased from 1-30-, 1930, to 2-6-, 1930, that I last saw him alive on 2-6-, 1930 and that death occurred, on the date stated above, at 3.03 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac: Myocardial insufficiency
Bronchial pneumonia

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia, alcoholism (duration) ____ yrs. ____ mos. 4 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? Yes Date of 2/5/30

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) Fred W. Stein, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Feb 10 1930

20 UNDERTAKER W Henry Lutz

ADDRESS 1203 Broadway

Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53862

CERTIFICATE OF DEATH.

90 E 53362

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1629 Appleton St., 15-21 Ward)

2-FULL NAME Rebecca Hirshberg

(a) RESIDENCE NO. 1629 Appleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lewis A. Hirshberg

6 DATE OF BIRTH (month, day, and year): June 13 1851

7 AGE: Years 78 Months 7 Days 27 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER Moses Black

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Cornelia Schloss

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. A. F. Black

(Address) 1629 Appleton St.

15 Filed C. H. MASON JONES, M. D. Registrar

1930 Reg. 1944

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1930 Feb 8-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1930, to Feb 8, 1930, that I last saw her alive on Feb. 8 —, 1930, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) annual yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Block, M. D.

, 19 (Address) 722 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Friendship Cemetery — Date of Burial 2/10 1930

20 UNDERTAKER: J. Ahrens & Co — ADDRESS 2432 Reisterstown Rd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53863

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53863

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 9-16 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgia Williams

(a) RESIDENCE NO. 2102 Aiken ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James W. Booze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Delcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 9-1930, 19 C. HARRISON JONES, Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8-30

17 I HEREBY CERTIFY That I attended deceased from 12-23-27, 19, to 2-8-30, 19, that I last saw her alive on 2-8-30, 19, and that death occurred, on the date stated above, at 2:15 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia & Hyp. Arteriosclerosis + Hypertension — unknown (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home; Secondary in hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Marvin M. McLean, M. D.

2-9, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 2/10/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul st

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53864 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53864

49

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 9-46 WARD)

2-FULL NAME Leo Wolfe

(a) RESIDENCE NO. 2706 Fivola Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 12-26-53

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Leo Wolfe

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Record
(Address)

Filed 1930. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7-30

17 I HEREBY CERTIFY, That I attended deceased from 2-3, 1930, to 2-7, 1930, that I last saw h[illegible] alive on 2-7, 1930, and that death occurred, on the date stated above, at 10:17 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma bladder - urinary

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2nr ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) L. U. Lumpkin, M. D.

2-8, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 2/10/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

FROM A VERY important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 53865 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53865

CERTIFICATE OF DEATH. 90

REGISTERED NO. 25-72

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 2736 Hartsinen ST. 25-72 WARD)

2-FULL NAME John Walz

(a) RESIDENCE NO. 2736 Hartsinen ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 26 mos. 7 da. How long in U. S., if of foreign birth? 30 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Walz

6 DATE OF BIRTH (month, day, and year) March 3-1854

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	75	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lena Lupus

(Address) 2736 Hartsinen St

Filed 9 1930 19 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1928 to Feb. 7, 1930, that I last saw h— alive on Feb. 7, 1930, and that death occurred, on the date stated above, at 11 30 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(duration) 2 yrs. 6 mos 1 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Krauss, M. D.

2/8, 1930 (Address) 1901 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery

DATE OF BURIAL 2/10 1930

ADDRESS

20 UNDERTAKER Mellain Cook 1217 W Paul St

Spec.—1-30—M. & T.—250 Blks.

E 53866

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

E 53866

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 11-24 WARD)

2-FULL NAME John Murray

(a) RESIDENCE NO. 831 Hamilton Terrace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct. 22 1869

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	60	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Michael Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Record
(Address)

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-30

17 I HEREBY CERTIFY, That I attended deceased from 1-24, 1930, to 2-6, 1930, that I last saw h[illegible] alive on 2-6, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix with partial obstruction

(duration) Unknown da.

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 1-28-30

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) L. U. Plimpton, M. D.

2-7, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL 2/10/30

20 UNDERTAKER George A. Farley ADDRESS Fulton & Fayette

Spec.—8-16-29—L. F. S.—100 Bks.

E 53867

HEALTH DEPARTMENT—CITY OF BALTIMORE

85 E 53867

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital REGISTERED NO. 21-29

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Volkmar

(a) RESIDENCE NO. 1022 W. Cross ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Volkmar

6 DATE OF BIRTH (month, day, and year) Dec 8 1852

7 AGE	Years	Months	Days	If L[illegible] than 1 da[illegible] hrs. or [illegible] min.
	77	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Dr. Gaul Fellows Private Family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER George Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Godfrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William Eidman

(Address) 1022 W. Cross

15 Filed ..... 19 ..... G. HAMPSON JONES, M. D. Registrar

FEB 9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from February 1st 1930, to February 6th 1930, that I last saw h[illegible] alive on February 5th 1930 and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Fracture of left patella

(Fill in 4 and at home)

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Exhaustion (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy + X-Ray

(Signed) Gunnis P. Gundry, M. D.

2-6-1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County

DATE OF BURIAL Feb 10 1930

20 UNDERTAKER Dyer Goodwin & Son

ADDRESS 2173 Re[illegible]

Spec.—8-16-29—L. F. S.—100 Bks.

E 53868

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53868

CERTIFICATE OF DEATH

45

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 E. 20th St. ST. 12-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara V. Horrall

(a) RESIDENCE NO. 214 E. 20th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac D. Horrall

6 DATE OF BIRTH (month, day, and year) Feb. 2-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Frederick Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Emberlie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs. Hazel V. Horrall

(Address) 214 E. 20th St.

15 Filed 2-8-1930. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7-1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1929 to Feb. 7, 1930.

that I last saw her alive on Feb. 7, 1930

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Julius Friedenwald, M. D.

Feb. 8. 1930 (Address) 1013 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL North East Md. DATE OF BURIAL Feb. 10 1930

20 UNDERTAKER Horace F. Burgee ADDRESS 3631 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

E 53869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

12-001

E 53869

1—PLACE OF DEATH

REGISTERED NO. 12

CITY OF BALTIMORE: (No. 507 W. Franklin ST. 17-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Harvey Griffith (Griffin)

(a) RESIDENCE NO. 507 W. Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Griffin

6 DATE OF BIRTH (month, day, and year): 2/30/1866

7 AGE: Years 63 | Months 11 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Clothing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Altoona Pa

PARENTS

10 NAME OF FATHER: Russell Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Stonestown Pa

12 MAIDEN NAME OF MOTHER: Parsifida Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Louisville Ky

14 Informant: Mrs Martha Griffin

(Address) 507 W Franklin

15 Filed FEB 9 1930, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB -8 1930

17

I HEREBY CERTIFY, That I attended deceased from December 1929, to Feb 8, 1930,

that I last saw him alive on February 6, 1930

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

nephritis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) Darius A. Baggott, M. D.

, 19 (Address) 1015 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westley Cemetery.

DATE OF BURIAL: Feb. 14 1930

20 UNDERTAKER: Bernard G Fink

ADDRESS: 734 Poplar Grove St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53870

CERTIFICATE OF DEATH

100-001

E 53870

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Hiller

(a) RESIDENCE NO. 400½ N. Camden ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 0&7

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Hiller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Lena Imhoff (sister) (Address) 402 S. Payson St

15 Filed C. HAMPTON JONES, M. D. 9-1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 - 30

17

I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1930, to Feb. 8, 1930, that I last saw h alive on Feb. 8, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

First - lobar pneumonia - bilateral gangrene.

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia - Septicemia - 2 days.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & Laboratory exam

(Signed) George H. Yeager, M. D.

Feb. 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL Feb. 10 1930

20 UNDERTAKER Harry A. Witzke ADDRESS 4101 Edmondson Ave.

Spec.—6-2-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53871

CERTIFICATE OF DEATH.

E 53871

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N Hilton St.) 70-79 (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A Fox

(a) RESIDENCE. No. 412 N. Hilton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S.,-if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo L Fox

6 DATE OF BIRTH (month, day, and year): Feb 7 1844

7 AGE: Years 86 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Donald T. Hammond (Address) 412 N Hilton

15 Filed ..... 19 C. HARRISON JONES, M. D., Registrar. By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 18th 1929 to Feb 7th 1930, that I last saw h[er] alive on Feb 6th 1930, and that death occurred, on the date stated above, at 11.30A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Jones M. D.

2/8, 1930 (Address) 720 N Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Feb 10 1930

20 UNDERTAKER: W M Routson

ADDRESS 223 N Mott

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

69 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53872 — 129 — E 53872

CERTIFICATE OF DEATH

REGISTERED NO. 2-16-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 S. Eaton St. ST. 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F. Ludwig

(a) RESIDENCE NO. 113 S. Eaton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Fredericka Ludwig

6 DATE OF BIRTH (month, day, and year): Mar 20/1863

7 AGE: Years 66 (65) | Months 10 (11) | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Mary Ludwig

(Address) 113 S. Eaton St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 7/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 19 30 to Feb 3 19 30

That I last saw h[illegible] alive on Jan 3 19 30

and that death occurred, on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Thrombosis or Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Nephritis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. M. Greenburg M. D.

2-6 1930 (Address) 4 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M. V. Garnet

DATE OF BURIAL: Feb 10 1930

20 UNDERTAKER: Philip Stewig

ADDRESS 2316 Orleans St

Spec.—2-29-28—L. F. S.—500 Blks.

E 53873

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53873

CERTIFICATE OF DEATH

REGISTERED NO. 31

1—PLACE OF DEATH Baltimore City Hospitals (TB)

CITY OF BALTIMORE: (No. ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H Talley

(a) RESIDENCE NO. 854 S. Bond st. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1894 Oct 27

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	35	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Stephen Talley

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Kaufman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed ____ 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1930, to Feb. 7, 1930, that I last saw him alive on Feb. 7, 1930 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jos. Arnold Jr. M. D.

2-7 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL Feb 11 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans st

FEB 10 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53874

E 53874

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 N. Lakewood Ave ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma V. Kraft

(a) RESIDENCE NO. 14 N. Lakewood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Christian W.

6 DATE OF BIRTH (month, day, and year): June 14/58

7 AGE: Years 71 | Months 7 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: John Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Mary R. Stortz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Nora L. Alexander

(Address): 14 N Lakewood Ave

15 FILED: B 1-8 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 8/30

17 Died suddenly.

I HEREBY CERTIFY, That I attended deceased from Feb 8, 1930, to Feb 8, 1930,

that I last saw her alive on Feb 6 - , 1930

and that death occurred, on the date stated above, at 11 A.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia -

cardio - vascular - renal (10 yrs) -

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Emphysema

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy exam

(Signed) Louis F. Krumm, M. D.

, 19 (Address) 722 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Mem.

DATE OF BURIAL: Feb. 11 1930

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans st

Spec.—1-10-21—M&T—1500 Blks.

E 53875

E 53875

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital ST. 9-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Hubert

(a) RESIDENCE NO. 1809 Aisquith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced (HUSBAND of or) WIFE of: John F. Hubert

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 66 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife & Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Wm Hubert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mrs Kerr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. John F. Hubert. (Address) 1809 Aisquith St

15 Filed FEB 1 1930, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-9- 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-8, 1930, to 2-9, 1930, that I last saw h[illegible] alive on 2-9, 1930, and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Coma

(duration) yrs. — mos. — 2 da.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. — mos. 2 hrs

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Thursley, M. D.

2/9, 1930 Address: St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Feb. 12 1930

20 UNDERTAKER: Henry Hoen & Sons, Inc. — ADDRESS: 130 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 1 1930

Cor.—10-10-29—A Co.—100 Bks.

E 53876

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53876

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital 10/15 St., Ward)

2-FULL NAME James J. Crawford

(a) RESIDENCE NO. 100 E Hardee St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. da.

REGISTERED NO. 118

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 39 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Gertrude Crawford

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
About	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stationary
(b) General nature of industry, business, or establishment in which employed (or employer) Engineer 030
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER William Crawford

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant Mr James J Crawford Jr.
(Address) 100 E Hardee St.

Filed 10 1930 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Int Obstruction

(duration) yrs. 1 mos. 2 da.

CONTRIBUTORY (Secondary) Fecal Pistonites

(duration) yrs. mos. 1 da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

What was there an autopsy? Yes

What test confirmed diagnosis? Histology

(Signed) H C Slade, M. D.

, 19 (Address) 43 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Cemetery Govans	Oct. 11 1930
20 UNDERTAKER	ADDRESS
Henry Aberle & Sons Inc.	130 E Eager St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53877 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53877

90

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 940 N. Bond ST. 713 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME A. Margaret Zentgraf

(a) RESIDENCE NO. 940 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Richard H. Zentgraf

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... Hrs. or ... min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Dosch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Richard H. Zentgraf

(Address) 940 N. Bond St.

15 Filed FEB 10 1930 C. H. McCOY JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 9 - 1930

17

I HEREBY CERTIFY, That I attended deceased from January 26, 1930, to February 9, 1930, that I last saw her alive on February 9, 1930 and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypertension Myocarditis

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Only

2/10, 1930 (Signed) J. M. Miller, M. D.

(Address) 1613 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	February 12 1930
20 UNDERTAKER	**ADDRESS**
Kenny Hoech & Sons, Inc.	1301 E Eager St

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53878

CERTIFICATE OF DEATH

89 ✓ E 53878

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 28-66

CITY OF BALTIMORE: (No. Fayette & Calhoun ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Helen Teresa Bolton

(a) RESIDENCE NO. Franklintown Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Bolton

6 DATE OF BIRTH (month, day, and year) August 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64	63	6		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Hartford County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Lahue

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mr. J. L. Bolton
(Address) 3442 Pedregal Ave.

15 [illegible] (Registrar)

EB 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1930, to Feb. 8, 1930, that I last saw her alive on Feb. 8, 1930 and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris causing acute cardiac failure

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis, Hypertension

(duration) many yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) M. B. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cem. Harford Co. Md.	2/11 1930
20 UNDERTAKER	ADDRESS
Henry U. Meads and Son	805 N. Calvert

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53379 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 ✓E 53379

CERTIFICATE OF DEATH

REGISTERED NO. 27-53

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5712 Roland Avenue ST. (WARD)

2—FULL NAME Margaret Schmitt

(a) RESIDENCE NO. 5712 Roland Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) ---------- 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) 065

(c) Name of employer

9 BIRTHPLACE (city or town) ------
(State or country) Germany

PARENTS

10 NAME OF FATHER Valentine Schmitt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Christina ----

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Sister M. P. Fitzgerald
(Address) 5712 Roland Avenue

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8-30

17 I HEREBY CERTIFY, That I attended deceased from September, 19 28, to Feb, 19 30, that I last saw h[illegible] alive on Feb 8th, 19 30 and that death occurred, on the date stated above, at 7[illegible] a.m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis with decompensation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydro thorax Rt.
at least (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Roentgen

(Signed) Charles Donovan Jr., M. D.

19 (Address) 1 East Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 2/10 19 30

20 UNDERTAKER: Henry U. Mears and Son

ADDRESS: 525 N. Calvert

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—1-10-21—M&T—1500 Bks.

E 53880 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 53880

CERTIFICATE OF DEATH. × 84

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 20-72 WARD)

2-FULL NAME Mrs Stephania Huber

(a) RESIDENCE NO. Rock Hall Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 31 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Huber

6 DATE OF BIRTH (month, day, and year) DEC 25 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	45	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Austria

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant (Address) Mr John Huber Rock Hall Md

15 Filed ..... 19 ..... Registrar

BT 01930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-17 1930 to 2-7 1930,

that I last saw h alive on 2-7 1930,

and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral tumor (glioma)

(duration) 1 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of 8-9-29 } 2 stages 8-20-29

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Section

(Signed) Ernest Spencer Jr. M. D.

19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A.C. DATE OF BURIAL 2-10th 1930

20 UNDERTAKER E & B Hurle 115 E West St ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53381 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 118-02 E 53381

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp ST., 11-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Leidner.

(a) RESIDENCE NO. Writing Landing on the Severn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 28 ds. 8 days How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna B Leidner

6 DATE OF BIRTH (month, day, and year) March 11-1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store keeper. 045

(b) General nature of industry, business, or establishment in which employed (or employer) Merchandise

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Henry Leidner.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Mrs Anna B Leidner

(Address) Writing Landing on the Severn

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/8/30.

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Feb 8, 1930, that I last saw him alive on Feb 8, 1930, and that death occurred, on the date stated above, at 10-25 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Cardiac failure.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? yes Date of 1/31/30.

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical symptoms.

(Signed) Henry A. Welch, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 2/11/1930

20 UNDERTAKER John F. Cowan & Son.

ADDRESS 901 Hollins St

Important. See instructions on back of certificates.

B TO 1930

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53882

CERTIFICATE OF DEATH.

188 103

E 53882

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp. 4-25 Ward)

2-FULL NAME Charles Jones

(a) RESIDENCE NO. 664 W. Fayette St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer) Farm

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country)

14 Informant For Inst. Aff. Boy.

(Address)

15 Filed FEB 10 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down and crushed between parked auto and another that was just moved in a collision acc.

CONTRIBUTORY (Secondary) Gangrene L. Leg result amputation (duration) Auto instant yrs. mos. ds.

(Signed) G. J. Fraser M. D.

(Coroner)

2/8, 1930 (Address) 2939 N. Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Douglas I. Pearl Ave.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery Date of Burial Feb 10, 1930

20 UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 53883 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53883

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1718 W Lexington St. St., 19-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Girl Jones.

(a) Residence No. 1718 W. Lexington St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb 7-1930

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 14 hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Charles Henry Jones.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Loudin Co. Virginia

12-MAIDEN NAME OF MOTHER, Madeline Hawthorne

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Aunt son D.C.

14- (Informant) Charles Henry Jones

(Address) 1718 W. Lexington st.

15- Filed FEB 1930 Registrar. C. H. [illegible] JONES, M.D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-7-1930

17- I HEREBY CERTIFY, That I attended deceased from 2-7-1930 to 2-7-1930 that I last saw her alive on 2-7-1930 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (36 wks)

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2/8. 1930 (Address) [illegible] Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	2-10-1930
20-UNDERTAKER. Dennis Carlin	ADDRESS 916 Pine.

Instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53884

CERTIFICATE OF DEATH

46 E 53884

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1830 W Lanvale St. 16-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine R. Thompson

(a) RESIDENCE NO. 1830 W Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ WIFE of D. M. Thompson

6 DATE OF BIRTH (month, day, and year) Feb 12 - 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	57	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ...

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. H. Snyder

11 BIRTHPLACE OF FATHER (City or town) ...

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eva R Garrett

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) Maryland

14 Informant D M Thompson

(Address) 1830 W Lanvale st

15 Filed ... 19 ... Registrar

B 10 1930 Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-7, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1928, to Feb 7, 1930, that I last saw h-e alive on Feb 9th, 1930 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia Influenza
Chronic Pneumonia
Nephritis (duration) as above yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

as above (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of About 1 mo Prior

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H K Gorsuch, M. D.

19 (Address) 117 W Saratoga St

2-10-30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sykesville Md — Date of Burial 2-12 1930

20 UNDERTAKER Edw Tipton — ADDRESS Hampstead Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53385

CERTIFICATE OF DEATH.

129 E 53385

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) West Baltimore General (Street) (Ward)

2-FULL NAME Mrs. Lillian Stormer.

(a) RESIDENCE NO. 814 E. Preston ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John W.

6 DATE OF BIRTH (month, day, and year) Aug 24 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	5	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of Industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Rudolph Walter
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Lena Eisser
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John W. Stormer
(Address) 332 W. Camden St

15 Filed FEB 10 1930 C. Hall Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 30 1930 to Feb. 9 1930
that I last saw h alive on Feb. 9. 1930
and that death occurred, on the date stated above, at 12.40 p. m
The CAUSE OF DEATH* was as follows:
Chronic glomerulo-nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.
Did an operation precede death? no Date of —
Was there an autopsy?
What test confirmed diagnosis? Clinical
(Signed) S. H. Alexander, M. D.
(Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL 2/12 1930

20 UNDERTAKER D. Wm Cook ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53886

CERTIFICATE OF DEATH.

3 1 E 53886

REGISTERED NO.

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. 8-17 S. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Geller

(a) RESIDENCE NO. 1632 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Geller

6 DATE OF BIRTH (month, day, and year): 6-3-1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: August Geller ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Stout ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Records (Address) BALTIMORE CITY HOSPITALS

15 Filed 2-10 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-8-30

17 I HEREBY CERTIFY, That I attended deceased from 2-7, 19 30, to 2-8, 19 30, that I last saw him alive on 2-8, 19 30, and that death occurred, on the date stated above, at 8-30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 3? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray: Autopsy

(Signed) Warren W. McCoach M. D.

2-9, 19 30 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: 2/12 19 30

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

FROM 5 very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53387

CERTIFICATE OF DEATH.

E 53387

REGISTERED NO.

1-PLACE OF DEATH St Agnes Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves (ST.) 25-72 (WARD)

2-FULL NAME Mrs Emma Sullevan

(a) RESIDENCE NO. 151 Clyde Ave (ST.) Lansdowne Md (WARD)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Virgil Sullevan

6 DATE OF BIRTH (month, day, and year): Aug 23 1890

7 AGE: Years 39 Months 5 Days 16 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm H Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Emma M. Rembardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs. George P. Johnson
(Address) 1723 Madison Ave

15 [illegible] 19 [illegible] Registrar

3 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-9 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-3 , 1930 , to 2-9 , 1930 ,
that I last saw her alive on 2-9 , 1930 ,
and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:
Coronary thrombosis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Geo Brewer M. D.
19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine — DATE OF BURIAL: 2/12 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1214 Gould St

CAUSE OF DEATH to be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53388

CERTIFICATE OF DEATH

101-001

E 53388

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 912 N. Gay St. (10-14 Ward)

2-FULL NAME Edward Schmitt

(a) RESIDENCE NO. 912 N. Gay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9/1876

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	53	7	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Musician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Jacob Schmitt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Agusta

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Capt. Charles Hahn (Bro-in-
(Address) 2701 Gwynn Oak Ave law)

15 Filed 1 01 1930 16 [illegible] Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) about Feb 5/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Exposure etc

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 2/10 1930

20 UNDERTAKER Wm. Cook

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 53889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 53889

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. 1005 S. Sharp St. St., 23-31 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henriette Kontner Hitaffer.

(a) RESIDENCE NO. 1005 S. Sharp St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 92 yrs. 1 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow.

5a If [illegible], widowed, [illegible] (or) WIFE of Thomas A. Hitaffer.

6 DATE OF BIRTH (month, day, and year) December 24, 1837

7 AGE	Years	Months	Days 13	IF LESS than 1 day hrs. or min.
	92	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Aller Braise.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Holland.

12 MAIDEN NAME OF MOTHER Annie Coleman.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Holland.

14 Informant Carrie Kontner (daughter)
(Address) 100 S. Sharp St.

15 Filed FEB 10 1930, 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 7, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Disease of the Heart and Kidneys.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

19 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Steinhardt, M. D.

2/8, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	2/11/30
20 UNDERTAKER John J. Fields	ADDRESS 1200 W. Baltimore

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53890

CERTIFICATE OF DEATH

45 ✓ E 53890

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem Hospital ST. 15-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Solomon Rosen

(a) RESIDENCE NO. 3813 Belle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced RUSHAND of (or) WIFE of Rachel Rosen

6 DATE OF BIRTH (month, day, and year) 10/2/1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper.

(b) General nature of industry, business, or establishment in which employed (or employer) 608

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Benjamin Rosen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosie Sheinden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8, 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930, to Feb 8, 1930, that I last saw h... alive on Feb 8, 1930 and that death occurred, on the date stated above, at 6.50 P.m.

The CAUSE OF DEATH* was as follows:

Resection of Sigmoid for Ca of rectum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Resection of Sigmoid

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Feb 1/30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nicholas Sanfourard, M. D.

2/8/1930 (Address) Union Mem Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Road — DATE OF BURIAL 2/10 1930

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53891

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 53891

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3716 Cottage Ave ST. 15-58 WARD)

2—FULL NAME Elaine Mazeroff

(a) RESIDENCE NO. 3716 Cottage Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: White Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 19-28

7 AGE: Years 1 | Months 7 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: David L. Mazeroff

11 BIRTHPLACE OF FATHER (city or town): ~~Baltimore~~ [illegible]

(State or country): ~~Md.~~ Russia

12 MAIDEN NAME OF MOTHER: Rose Esenberg

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Russia

14 Informant: David L. Mazeroff

(Address) 3716 Cottage Ave

15 Filed 19 C. HARRISON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-9-30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1930, to Feb. 9, 1930, that I last saw her alive on Feb. 8, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Routine

(Signed) Herman J. Dorf, M. D.

2/9, 1930 (Address) 3730 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kehser Mt Carmel

DATE OF BURIAL: 2/10 1930

20 UNDERTAKER: Jack Lewis 1439 E Balto St

ADDRESS

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53892 160 ✓ E 53892

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2911 Shirley ave ST 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank. Bennett

(a) RESIDENCE NO. 2911 Shirley ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 6 - 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER J. Gordon Bennett

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mamie A. Edels

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant J. Gordon Bennett
(Address) 2911 Shirley ave.

15 Filed ....., 19 ..... Registrar

FEB 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 19 30, to Feb 8, 19 30

that I last saw h. l. m. alive on Feb 8, 19 30

and that death occurred, on the date stated above, at 8 30 A m.

The CAUSE OF DEATH* was as follows:

Immature Placenta

(duration) ....yrs....mos. about

CONTRIBUTORY (Secondary)

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Cushing, M. D.

Feb 8, 19 30 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Feb 10 19 30

20 UNDERTAKER George W. Zickler

ADDRESS 737 E. Eager St

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53393

CERTIFICATE OF DEATH.

161-001 E 53893

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 70-71 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Alban

(a) RESIDENCE NO. 308 S. Collins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~~

6 DATE OF BIRTH (month, day, and year) 2/9/30.

7 AGE Years Months Days / If LESS than 1 day, 3 hrs. or ..... min.

8 OCCUPATION OF DECEASED ~~~ 800

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Alban

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma C. Foley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant George Jerome Alban

(Address) 308 S. Collins

15 Filed FEB 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-9 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-9 .19 30. to 2-9 .19 30.

that I last saw him alive on 2-9 .19 30.

and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Paul Cohen, M. D.

.19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 2-10 1930

20 UNDERTAKER C. Tho Dill

ADDRESS 3109 Fred

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53894

CERTIFICATE OF DEATH.

74 901 E 53894

REGISTERED NO. 13459

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2512 Woodbrook ST. 13th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Glessner

(a) RESIDENCE NO. 2512 Woodbrook ST. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (~~HUSBAND~~ or) WIFE of Hamilton A. Glessner

6 DATE OF BIRTH (month, day, and year) Sept 1. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	6.	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Havre de Grace Md.

PARENTS

10 NAME OF FATHER Moses Yokonay

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Henrietta Bruns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Helen Meisler (Address) 2512 Woodbrook Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1930

17 I HEREBY CERTIFY, That I attended deceased from several years ago 19 ..... to Feb. 8 .1930.

that I last saw her alive on Feb. 7 .1930,

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

last attack, 8 days, but several before.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs & symptoms

(Signed) L. X. Schmidt, M. D.

Feb. 9. 1930 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Louden Park Cem DATE OF BURIAL Feb 11 1930

20 UNDERTAKER Josiah Effler ADDRESS 1600 N. Howard St.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 53895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 ✓ E 53895

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N. Patterson Pk St. 9th WARD)

2-FULL NAME William J. McDonald

(a) RESIDENCE No. 916 N Patterson Pk Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara McDonald

6 DATE OF BIRTH (month, day, and year): Oct 2nd 1869

7 AGE: Years 60 | Months 3 4 | Days 5 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Fire Chief

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer: Balto City

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Alex. McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not Given

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Given

14 Informant: Barbara McDonald

(Address) 916 N Patterson Pk Ave

15 Filed FEB 10 1930 C. E. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Feb 7, 1930

that I last saw him alive on Feb 5, 1930

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cerebral Embolism

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

1930 (Address) 800 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Holy Redeemer

DATE OF BURIAL: Feb 9 1930

20 UNDERTAKER: Jos M. Frick & Son

ADDRESS: 811 N Howard

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53896

HEALTH DEPARTMENT—CITY OF BALTIMORE

84E 53896

CERTIFICATE OF DEATH

REGISTERED NO. 20-69

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2512 N. Henry ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. Ehmann

(a) RESIDENCE NO. 2512 N. Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 5 mos. 6 dys. How long in U. S., if foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Ehmann

6 DATE OF BIRTH (month, day, and year): Sept 14th 1884

7 AGE: Years 45 Months 5 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): Somebody Else

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Rudolph Ehmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christine Kienard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Minnie Ehmann

(Address) 2512 N. Henry St.

15 Filed ..., 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/8/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1930, to Feb 8, 1930

that I last saw h alive on Feb 8, 1930

and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

8 hours (duration)

CONTRIBUTORY (Secondary): Hypertension Arteriosclerosis indefinite (duration)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kahn M. D.

2/8, 1930 (Address) W 27 Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb 11th 1930

20 UNDERTAKER: F. B. Klippert

ADDRESS: 1550 N. Balto St

Important. See instructions on back of certificates.

FEB 10 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53897.

CERTIFICATE OF DEATH

REGISTERED NO. 12 E V 53897.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2117 W. Lexington ST. 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leo A. Donnelly

(a) RESIDENCE NO. 2117 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

(6 If married, widowed, or divorced) HUSBAND of (or) WIFE of Marie L. Donnelly

6 DATE OF BIRTH (month, day, and year) Aug 5th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	48	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Veterinarian

(b) General nature of industry, business, or establishment in which employed (or employer) United Electric Co.

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ellicott City Md.

12 MAIDEN NAME OF MOTHER Catherine F. Tallman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D. C.

14 Informant Marie L. Donnelly

(Address) 2117 W. Lexington St.

Filed FEB 10 1930 C. EDMONDSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/7/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 1- 1930, to Feb. 7. 1930

that I last saw him alive on Feb 7- 1930

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute Glomerular Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. E. Burton M. D.

2/8. 1930 (Address) 301 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb 11th 1930
20. UNDERTAKER	ADDRESS
J. B. Kupfrian	1850 W. Baltimore St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E-53898

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53898

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO. 20-69

CITY OF BALTIMORE: (No.) 121 (ST.) Willard (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anton Bossert

(a) RESIDENCE NO. 121 (ST.) Willard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Bossert

6 DATE OF BIRTH (month, day, and year): June 6th 1854

7 AGE: Years 75 | Months 8 | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer): Sausage mfg

(c) Name of employer: Proprietor

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: David Bossert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna Bossert

(Address) 121 Willard St

Filed ..... 19..... Registrar

C. EARLESON JONES, M. D.

FEB 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 6th 30

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1930 to Feb 6 1930

that I last saw him alive on Feb 6 1930

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Heather [illegible] M. D.

2/9 1930 (Address) 542 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb 10th 1930

20 UNDERTAKER: H. A. Kyselka & Sons

ADDRESS: 1100 N. Eutaw St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 53899

1—PLACE OF DEATH Md General Hosp (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 Wright Madison ST. 28-64 WARD)

2—FULL NAME Thomas Leonard

(a) RESIDENCE NO. 5202 Westley Ave ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 29, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	10	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Michael Leonard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Gilbey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hosp Records
(Address)

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-8-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 19 30 to Feb 8, 19 30
that I last saw h alive on Feb 8, 19 30
and that death occurred, on the date stated above, at 7 45 a.m.

The CAUSE OF DEATH* was as follows:
Acute Gangrenous Appendicit
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Peritonitis
(duration) yrs. mos. ? ds.

18 Where was disease contracted ✓
If not at place of death?
Did an operation precede death? Yes Date of Feb 3
Was there an autopsy? No
What test confirmed diagnosis? Operation
(Signed) H E Kirpatrick M. D.
2/8, 19 30 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — DATE OF BURIAL 2/11/30

20 UNDERTAKER H E Bamberger & Co — ADDRESS 1136 Park Ave

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53900

E 53900

CERTIFICATE OF DEATH

179

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 26-37 WARD)

2—FULL NAME Oscar Stuprich (STUPRICH)

(a) RESIDENCE NO. 254 S. Eaton ST. 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23rd 1909

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	20	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Acetylene Burner

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Union Shipbuilding Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Oscar Stuprich Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Teresa Stelmar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Oscar Stuprich

(Address) 254 S. Eaton St

15 Filed FEB 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930, to Feb 8, 1930, that I last saw him alive on Feb 8, 1930, and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

First, second and third degree burns of lower half of body - accidental Ignited from acetylene torch

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Union Shipbuilding Yards

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Samuel J. Helfman, M. D.

, 19 (Address) Towson Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL Feb 12th 1930

20 UNDERTAKER Lilly & Geiler Inc.

ADDRESS 403 S. Wolfe St.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Benjamin Walderman

E 53901

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53901

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2221 E. Balto St., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjamin Walderman

(a) RESIDENCE NO. 2221 E [redacted] ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Walderman

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	92	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abram Walderman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Minkow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balto St

15 Filed 1 0 1930 C. H. [redacted]COX JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1926, to Feb 9, 1930, that I last saw h[redacted] alive on Feb 9 1930 and that death occurred, on the date stated above, at 3 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial insuff.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examinations

(Signed) Jacob Cohen, M. D.

2/10, 1930 (Address) 223 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 2/10 1930

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53902

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53902

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 W Lafayette St. 17-24 WARD)

2-FULL NAME Agnes A Saunderson

(a) RESIDENCE NO. 523 W Lafayette St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A C Saunderson

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thomas Tyler

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Julia Tabb

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Julia Tabb
(Address) 121 Linden St.

15 Filed FEB 16 1930 19 H. [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 8/30

17 I HEREBY CERTIFY, That I attended deceased from Feby 4 1930, to Feby 8 1930,

that I last saw her alive on Feby 8 1930,

and that death occurred, on the date stated above, at 6.15 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy

(duration) ... yrs. ... mos 4 days

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of ...

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) B N Hatcher M. D.

2/9, 1930 (Address) 1225 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampton Va

DATE OF BURIAL Feby 9 1930

20 UNDERTAKER Steuart Easton

ADDRESS 916 1/2 Park Ave

FROM very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53903

90

1—PLACE OF DEATH

REGISTERED NO. 76-37

CITY OF BALTIMORE: (No. 3924 Eastern Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Geltman

(a) RESIDENCE NO. 3924 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Geltman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Charles Geltman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Yorkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1434 Edgecliff

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/10/30

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1925, to Feb. 10, 1930, that I last saw h in alive on Feb. 10, 1930 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

myocardial Insufficiency

Cardiac Hypertrophy

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical, Lab.

(Signed) R A Nicholson, M. D.

Feb 10, 1930 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 2/10 1930

20 UNDERTAKER Jack Lewis 1434 Edgecliff

ADDRESS

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53904

CERTIFICATE OF DEATH

38 E 53904

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1002 S. Eutaw St. St. 21-31 Ward)

2-FULL NAME William Fletcher. (C)

(a) RESIDENCE NO. 1002 S. Eutaw St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)
Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	85	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER
Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address) UNIVERSITY OF MARYLAND

15 Filed ..... 19.... Registrar

FEB 1 1930

4379

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) February 2, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Syphilis.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Reinhardt, M. D.

2/6, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53905

CERTIFICATE OF DEATH

89 ✓ E 53905

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 Bolton ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sallie Roberts Beasley

(a) RESIDENCE NO. 1220 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Beasley

6 DATE OF BIRTH (month, day, and year): Aug. 30, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Jos. K. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Edith Bowie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Edith Stanley

(Address) 1220 Bolton St.

15 Filed: C 19 H. K. JONES, M. Registrar

LO 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to Feb 9, 1930, that I last saw h[illegible] alive on Feb 9, 1930 and that death occurred, on the date stated above, at 6.35 a.m.

The CAUSE OF DEATH* was as follows:

Angina pectoris (Coronary Thrombosis)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. S. Davis, M. D.

2/10, 1930 (Address) 720 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem.

DATE OF BURIAL: Feb. 11, 1930

20 UNDERTAKER: John C. Mitchell & Son

ADDRESS: 1900 Eutaw P[illegible]

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 53906

E 53906

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W. Hartman

(a) RESIDENCE NO. 1627 Alice Anna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hartman

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Karl Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Emma Hartman

(Address) 1627 Alice Anna St

15 FILED ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 3, 1930, to February 8, 1930, that I last saw him alive on February 8, 1930 and that death occurred, on the date stated above, at 8:15 A.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic heart disease

Chronic nephritis.

(duration) 3/4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute congestive failure with anasarca (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel T. Hebel, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb. 12 1930
20 UNDERTAKER	ADDRESS
Henry Sander & Sons. Inc.	Baltimore St & Broadway

Important. See instructions on back of certificates.

FEB 16 1930 C. L. PHONES

Spec.-7-17-26—A Co.—200 Bks.

E 53907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

4th E 53907

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2310 Race St. 23-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Jarz

(a) RESIDENCE NO. 2310 Race St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Magdalena Jarz

6 DATE OF BIRTH (month, day, and year): aug 27 1866

7 AGE: Years 63 Months 5 Days 11 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): B.&O. R.R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (City or town) (State or country): Europe

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Europe

14 Informant: Mrs. John Jarz

(Address): 2310 Race St.

15 Filed 19 C. BAMBERGER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1930 Feb 8

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1930 to Feb 8 1930

that I last saw h alive on Jan 7 1930

and that death occurred, on the date stated above, at 12-35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(daration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Dec 10 1929

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. E. Campbell M. D.

2/9. 1930 (Address) 1644 Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. a.a

Date of Burial: Feb. 11 1930

20 UNDERTAKER: Margaret A. Flynn

ADDRESS: 1422 Light

FILED TO 1930

The above to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53908

CERTIFICATE OF DEATH.

129 E 53908

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Asquith St 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Crews

(a) RESIDENCE NO. 207 Asquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Unknown Apr 64 yrs

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 64				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 870

(b) General nature of industry, business, or establishment in which employed (or employer) General Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hagerstown Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Mary Wilson (Address) 1732 Druid Hill Ave

15 Filed ..... 19.. Registrar

FEB 10 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1929, to Feb 10, 1930, that I last saw h alive on Feb 8, 1930 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Gundy M.D.

2/10, 1930 (Address) 1424 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md

UNDERTAKER Joseph A. Lively

DATE OF BURIAL Feb 11 1930

ADDRESS 409 N Mount

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53909 X 49 E 53909

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital 4-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Ruff

(a) RESIDENCE NO. Bel Air Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1½ mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jennie Ruff

6 DATE OF BIRTH (month, day, and year) Oct 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	67	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bel Air (State or country) Md

PARENTS

10 NAME OF FATHER Asbury Ruff

11 BIRTHPLACE OF FATHER (city or town) Bel Air (State or country) Md

12 MAIDEN NAME OF MOTHER Mary (?)

13 BIRTHPLACE OF MOTHER (city or town) Bel Air (State or country) Md

14 Informant Margaret Moser

(Address) 813 Mount St

15 FEB 10 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-9-30

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1930, to Feb 9, 1930

that I last saw him alive on Feb 9, 1930

and that death occurred, on the date stated above, at 3.00 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas with metastasis to Liver, Spleen Gall Bladder & Omentum

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hendon Hill — DATE OF BURIAL Feby 12 1930

20 UNDERTAKER Dean & Foster — ADDRESS Bel Air Md

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

(Muchna)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53910

101 9 01 E 53310

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2228 Hanover ST., 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Muchna

(a) RESIDENCE NO. 2228 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonette Muchna

6 DATE OF BIRTH (month, day, and year) May 25 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Muchna

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Antonette Muchna

(Address) 2228 Hanover

15 Filed 10 1930 C. H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8/30

17

I HEREBY CERTIFY, That I attended deceased from Jan 9 1930 to Feb 8 1930

that I last saw h alive on Jan 9 1930

and that death occurred, on the date stated above, at 2.46 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

1 wk.

(duration) yr. mo. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Leichliter M. D.

2830 Address 800 N Dallas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Feb 11 1930

20 UNDERTAKER Frank Brach & Son 1906

ADDRESS Gaithersburg Md

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53911

CERTIFICATE OF DEATH

159-902 E 53911

1—PLACE OF DEATH

REGISTERED NO. 26-37

CITY OF BALTIMORE: (No. 1006 S. Conkling ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Hutchinson, Jr.

(a) RESIDENCE NO. 1006 S. Conkling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 7 da. How long in U. S., if foreign birth? — yrs. — mos. — da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 2-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John H. Hutchinson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Grammer

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant John H. Hutchinson (Address) 1006 S. Conkling St

15 Filed OCT 10 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1930, to February 9, 1930, that I last saw him alive on Feb. 8, 1930 and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Robacy some Coma Vitae Reflex defect.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Jos. A. Rosenstein, M. D.

2/10, 19 30 (Address) 608 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel cem.

DATE OF BURIAL Feb. 11 1930

20 UNDERTAKER George W. Zinkle

ADDRESS 1737 E. Eager

Important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 53912 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 721 W. Mulberry St., 4-26 Ward)

Registered No. 161-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Robinson

(a) Residence No. 721 W. Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Feb. 2, 1930

7-AGE. 8 yrs. 9 mos. 9 ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md. (State or Country).

PARENTS.

10-NAME OF FATHER, Samuel Robinson

11-BIRTHPLACE OF FATHER (city or town) Westmoreland. (State or Country), W. Virginia

12-MAIDEN NAME OF MOTHER, Jennie Noel

13-BIRTHPLACE OF MOTHER (city or town) Essex, (State or Country), Virginia

14- (Informant) Jennie Noel Robinson

(Address) 721 W. Mulberry St.

15- C. HAMPSON JONES, M. D.

FEB 10 1930

4350

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb 10, 1930.

17- I HEREBY CERTIFY, That I attended deceased from Feb 2. 1930 to Feb 10 1930.

that I last saw him alive on Feb 10 1930.

and that death occurred, on the date stated above, at 9:30A. m.

The CAUSE OF DEATH* was as follows:

Prematurity.

Twin pregnancy.

Coma #2 V

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mis Tamar Copeman

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jean L. Douglass M. D.

2/10. 1930 (Address) Univ. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. ....., 19....
20-UNDERTAKER. Dean	ADDRESS

REGISTRAR OF VITAL STATISTICS STATE OF MARYLAND FEB 10 1930

Instructions on back of certificates. Each statement of OCCUPATION is very important. See

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53913 ✓ E 53913

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hosp (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Evelyn E Jones

(a) RESIDENCE NO. 2581 W. Fayette St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Levering N. Jones

6 DATE OF BIRTH (month, day, and year) October 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John D. Newbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Christine Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Alverta E. Reier

(Address) 416 W. Pratt St.

15 Filed 10 1930, 19 C. H. AMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9/30

17 I HEREBY CERTIFY, That I attended deceased from 2/6, 1930, to 2/9, 1930, that I last saw h[illegible] alive on 2/8, 1930 and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic cardiovascular renal disease.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thos E. Shey Jr, M. D.

2/9, 1930 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feb. 11 1930

UNDERTAKER Joseph D Cook

ADDRESS 1003 West Baltimore St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 53914 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital REGISTERED NO. .....

CITY OF BALTIMORE: (No. Caton & Wilkes Aves St. 25-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Reese

(a) RESIDENCE NO. Fairfield Pa. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stella Sanders Reese

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: George

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Alice Sanders (Address) Fairfield Pa

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-9 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-29, 1930, to 2-9, 1930, that I last saw him alive on 2-9, 1930, and that death occurred, on the date stated above, at 8.05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 6 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Generalized Metastases

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Feb 6-30

Was there an autopsy? yes

What test confirmed diagnosis? Frozen Section

(Signed) Ernest Spencer Jr., M. D.

, 19 (Address) St agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairfield Pa.

DATE OF BURIAL: Feb 11 1930

20 UNDERTAKER: Martin Bakey & Sons

ADDRESS: 1827 W. North Ave

Cor.—10-10-29—A Co.—100 Bks.

E 53915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 53915

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital St. (9-9 Ward)

2-FULL NAME George P. Phillips

(a) RESIDENCE NO. 610 N. Castle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Joanna R. Phillips

6 DATE OF BIRTH (month, day, and year) Oct 7th 1864

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
65.	4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter 015
(b) General nature of industry, business, or establishment in which employed (or employer): Building Trade
(c) Name of employer: Self

9 BIRTHPLACE (city or town)
(State or country) Milwaukee

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Milwaukee

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Milwaukee

14 Informant Mrs Joanna R Phillips
(Address) 610 N. Castle st

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

8 19 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Nephritis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Phy Ex

(Signed) G. C. Eades, M. D.

, 19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL: Ivy Hill, Laurel, Md

DATE OF BURIAL: 2/11 1930

20 UNDERTAKER: H M Croft

ADDRESS: 12 1/2 E Pond St

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 53916

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53916

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1422 Bolton St. 14-20 (WARD)

2-FULL NAME Miss Emma Rosalie Hooper

(a) RESIDENCE NO. 1422 Bolton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 2 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary G. Brannan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. Mark L. Daniels (Address)

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9, 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 29, 1930, to Feb 9, 1930, that I last saw h[illegible] alive on Feb 7, 1930, and that death occurred, on the date stated above, at 6 55 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio Vascular Disease
Chronic myocarditis Heart Block

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Raymond Peters, M. D.

, 19 (Address) 1908 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Feb 11, 1930

20 UNDERTAKER Stewart & Co. — ADDRESS Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 10 1930 G. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53917

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 53917

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 101 Tinges Lane ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Grieber Rusk

(a) RESIDENCE NO. 101 Tinges Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 8 mos. 12 dys. How long in U. S., if foreign birth? 55 yrs. 8 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna E. Rusk

6 DATE OF BIRTH (month, day, and year) May 28 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer Geo. P. Gable Adj. Co.

9 BIRTHPLACE (city or town) Balto.

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Rusk

11 BIRTHPLACE OF FATHER (city or town) Degmier

(State or country) Indiana

12 MAIDEN NAME OF MOTHER Josephine Elster

13 BIRTHPLACE OF MOTHER (city or town) Cumberland

(State or country) Maryland

14 Informant Mrs. Mo. G. Price Jr. (Sister)

(Address) Roland Park, City

15 Filed Feb 10 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 9th 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec 7, 1929, to Feb 9, 1930, that I last saw h... alive on Feb 9, 1930 and that death occurred, on the date stated above, at 11 0 m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

Aortic Stenosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. G. Prentiss, M. D.

. 19 (Address) 634 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb 11 1930
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53918

CERTIFICATE OF DEATH

X 86-001

E 53918

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital St. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles E. Elkins

(a) RESIDENCE NO. Towson Md. Old Harford Rd. ST. Route 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie V. Elkins

6 DATE OF BIRTH (month, day, and year) April 1st 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer McMahon Trans. Co.

9 BIRTHPLACE (city or town) Culpepper Co. (State or country) Virginia

PARENTS

10 NAME OF FATHER Richard H. Elkins

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sallie C. Taylor

13 BIRTHPLACE OF MOTHER (city or town) Madison Co. (State or country) Virginia

14 Informant Nellie V. Elkins

(Address) 4 Madeline Ave. Overlea

15 FEB 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 0, 19 30, to Feb 9, 19 30, that I last saw him alive on Feb 9, 19 30 and that death occurred, on the date stated above, at 10 30 p.m.

The CAUSE OF DEATH* was as follows: 8-001 71-9

Acute Suppurative otitis media with purulent leptomeningitis (pneumococcic)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Bacteriological

(Signed) Samuel J. Stokes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Feb. 12 30
20 UNDERTAKER	ADDRESS
Frederick Loose & Sons	Fullerton

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53919

CERTIFICATE OF DEATH

E 53919

1—PLACE OF DEATH

REGISTERED NO. 49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. [illegible] WARD)

2—FULL NAME Emma B. Totterdale

(a) RESIDENCE NO. 406 Oak Knoll Ave ST., Warren, Ohio WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec ? 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	1	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER John Granger

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah Boden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Granger Totterdale

(Address) Warren, Ohio

15 Filed ... 19 ... Registrar

C. E. THOMPSON JONES, M.D.

1 0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10-1930

17

I HEREBY CERTIFY, That I attended deceased from February 6 1930 to February 10, 1930, that I last saw her alive on February 10, 1930 and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Obstructive Jaundice

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes (Cholecyst-duodenostomy) Date of Feb 7, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vernon H. Norwood, M. D.

2/10, 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Warren, Ohio

DATE OF BURIAL Feb 10 1930

20 UNDERTAKER Wm J Tuckey, Jones

ADDRESS Ft Lake

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53920 ✓ 47 E 53920

CERTIFICATE OF DEATH

E 53920

REGISTERED NO. 47

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1605 Clarkson. ST. 23-32 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Hoffman

(a) RESIDENCE NO. 1605 Clarkson. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1st 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook. 021

(b) General nature of industry, business, or establishment in which employed (or employer): Mrs Delany

(c) Name of employer: Washington Apt.

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Geo Hoffman.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Margt Hettrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Mary Hoffman.

(Address) 1605 Clarkson St

15 Filed 19 Registrar

C. HARRISON JONES, M. D.

10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8th 1930

17 I HEREBY CERTIFY That I attended deceased from Jan 5, 1930, to Feb 8, 1930.

That I last saw her alive on Feb 8, 1930.

and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast.

or

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Yes.

Did an operation precede death? Yes Date of Jan 5, 1930.

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Biopsy

(Signed) John L. Schmunk, M. D.

19 (Address) 1337 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. A. Co.

DATE OF BURIAL: 2-11 1930

20 UNDERTAKER: E. B. Hark 1156

ADDRESS: West St.

Important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53021. 44 E 53021

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 S. High ST. 58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francesco Darago

(a) RESIDENCE NO. 236 S. High ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced WIFE (or HUSBAND) of Maria Darago

6 DATE OF BIRTH (month, day, and year) Dec 17-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vito Darago

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Fiora

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Maria Darago

(Address) 236 S. High St

15 Filed FEB 10 1930, 19 C. EDMONSON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to Feb 8, 1930, that I last saw him alive on Feb 7, 1930 and that death occurred, on the date stated above, at 6.20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D'Stefano M. D.

Feb 8, 1930 (Address) 407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

UNDERTAKER Wendell & Leopel

DATE OF BURIAL Feb 11 1930

ADDRESS 300 S Colvin

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 53922

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53922

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 227 S Highland St WARD) 23-5

2—FULL NAME Frances Pittelli

(a) RESIDENCE NO. 227 S Highland St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Pittelli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Catherine Riverso

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Pittelli

(Address) 227 S Highland St

15 Filed Feb 10 1930 Clarence Jones Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1930

17 Dec. 28-29

I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930, to Feb. 8, 1930, that I last saw her alive on Feb. 7, 1930 and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma, gastric

Contributory

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not 1928

Did an operation precede death? Yes Date of Feb. 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. W. Cook, M. D.

2-10, 1930 (Address) 1117 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 12 1930
20 UNDERTAKER	ADDRESS
M. F. & E. Dippold Inc	37 E Lanvale

Important. See instructions on back of certificates. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53923 E 53923

CERTIFICATE OF DEATH.

REGISTERED NO. 100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3008 Windsor Ave (WARD) 45-61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S Brooke

(a) RESIDENCE No. 3008 Windsor Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20 1844

7 AGE: 85 Years 7 Months 19 Days — If LESS than 1 day, hrs. or min.

86

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: David Carson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Rebecca Hamphillion

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Nannie L Brooke

(Address) 3008 Windsor Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 7 , 1930 , to Feb 8 , 1930 ,

that I last saw her alive on Feb 8 , 1930

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cardio dialation

Terminal Pneumonia

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H. D. Finch M. D.

19 (Address) 9 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: Feb 11

20 UNDERTAKER: George J Smith — ADDR: Hav

FEB 10 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53924 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53924

45

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 16 Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Maurer

(a) RESIDENCE No. 2007 W. Lanvale St., Ward
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Maurer

6 DATE OF BIRTH (month, day, and year) 6-21-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Movie operator

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Maurer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10-30

17 I HEREBY CERTIFY, That I attended deceased from 1-22, 1930, to 2-10, 1930, that I last saw h~~im~~ alive on 2-10, 1930, and that death occurred, on the date stated above, at 3:07 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of spleen, pleura, colon

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. H. Lumpkin, M. D.

2-10, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 2/13/

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul

THIS IS very important See instructions on back of certificates.

Spec.—2-19-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53925

CERTIFICATE OF DEATH

90 ✓ E 53925

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 448 E. Cross ST. 24th WARD 33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F. P. Ward

(a) RESIDENCE NO. 448 E. Cross ST., 24th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 3 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Ward

6 DATE OF BIRTH (month, day, and year) Nov 2, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown.
(State or country)

14 Informant Annie M. Ward (daughter)
(Address) 448 E. Cross St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 10, 1930, that I last saw him alive on Feb 9, 1930 and that death occurred, on the date stated above, at 8 00 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

Feb 10, 1930 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park | DATE OF BURIAL Feb 12

20 UNDERTAKER [illegible] | ADDRESS [illegible]

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53926 31 E 53926

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 25-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Holland

(a) RESIDENCE NO. 2037 Annapolis Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Holland

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Rowan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Recores
(Address)

15 B 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to Feb. 9, 1930, that I last saw her alive on Feb. 9, 1930 and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

2-10, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Brooklyn) Cemetery

DATE OF BURIAL 2/14

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

Burial permit is not granted, as that is only the property classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53927 HEALTH DEPARTMENT—CITY OF BALTIMORE 53927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 1-3 WARD)

REGISTERED NO. 100-09

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Feller

(a) RESIDENCE No. 600 S. Milton Ave. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Feller ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) Jan. 3, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Zanetzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

101930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10-30

17 I HEREBY CERTIFY, That I attended deceased from 2-5-30, 19..., to 2-10-30, 19...,

that I last saw her alive on 2-10-30, 19...,

and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Prolapse of Uterus & Cystocele

Atelectasis (duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McLean, M. D.

2/10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Feb 13 19

20 UNDERTAKER Henry Sauer & Sons, Inc.

ADDRESS Baltimore & Broa...

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

53928 E 53928 9

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 511 Laurens ST. 14-20 WARD)

2—FULL NAME Gloria M. Newton

(a) RESIDENCE NO. 511 Laurens ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-30-29

7 AGE: Years 2 Months Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home Child
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Howard V. Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Lou

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Howard V. Newton
(Address) 511 Laurens St

15 Filed 19 Registrar

B 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 9, 1930, that I last saw h.. alive on Feb 8, 1930 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pertussis (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McLeod M. D.

2/10, 1930 (Address) 2029 O'Dell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. DATE OF BURIAL 2-11 1930

20 UNDERTAKER Frank T. A. Gibson ADDRESS 1734 Druid Hill Ave

important. See instructions on back of certificates.

Spec.--2-29-28--L. F. S.--500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53929 ✓ 129 E 53929

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 Hull St. ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julian Sadowski

(a) RESIDENCE NO. 1205 Hull St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 26 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58 30	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Rozalia Sadowski

(Address) 1205 Hull St.

15 Filed FEB 10 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1930, to Feb. 9, 1930

that I last saw h[illegible] alive on Feb. 8, 1930

and that death occurred, on the date stated above, at 4 A.m.

The CAUSE OF DEATH* was as follows:

Hypertension, Arteria Sclerosis, Mitral Reg. (Compensated) Chronic Interstitial Nephritis, Uraemia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Mitral Reg. Arter Scl. Interstitial Nep.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine + Sph.

(Signed) Thos. F. Stevens, M. D.

2/10, 1930 (Address) 2878 Halford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Feb. 12 1930
20 UNDERTAKER	ADDRESS
John M Weber	Old Chester Rd

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Conlon) ✓

E 53930

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53930

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Joseph's Hospital Eastlake Ave ST., 9th WARD)

2-FULL NAME Mrs. Mary E. Conlon

(a) RESIDENCE NO. 1109 E. Northern Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James M. Conlon

6 DATE OF BIRTH (month, day, and year) 7/4/1870

7 AGE: Years 59 | Months 7 | Days 6 | If LESS than 1 day, ~~hrs.~~ or ~~min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Owen Coffey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Dougherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: James M. Conlon
(Address)

15 Filed FEB 10 1930, 19 C. EARNSHAW JONES, M. D. Registrar RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/10 19 30.

17 I HEREBY CERTIFY, That I attended deceased from 1-19, 19 30, to 2-10, 19 30.

That I last saw h~~e~~r alive on 2-10, 19 30

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Diabetes - 2 yrs
Hemiplegia - 4 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
3 days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. B. Chandler, M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL 2/11/30

20 UNDERTAKER: George J. Pattle & Son — ADDRESS 1730 Harford

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53931

CERTIFICATE OF DEATH.

90 E 53931

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1019 S. Hanover St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elvira Castagnetto

(a) RESIDENCE NO. 1019 S. Hanover St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Alexander

6 DATE OF BIRTH (month, day, and year) Aug. 10 - 1865

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Andrew -

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Livia

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Alexander Castagnetto

(Address)

10 1930 19 C. LAMPSON JONES Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb. 7/ 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1930, to Feb. 7, 1930,

that I last saw h~~e~~r alive on Feb. 7, 1930,

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Phil. Costantigiani, M. D.

, 19 (Address) 2942 E. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

Date of Burial 2/11/30

20 UNDERTAKER George D. Wirth & Son

ADDRESS 1235 Hollins

DO NOT FOLD

Do not attempt to correct any supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 E 53932

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 E. Lanvale ST. 9-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Young Dutkehar

(a) RESIDENCE NO. 1428 E Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	25 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) Huckster

(c) Name of employer Retired

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Mr B Dutkehardt

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mutsenard

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs. James Doerting

(Address) 14 E. 2 Edmondson Ave

15 Filed ..... 19.. Registrar

C. HUMPSON JONES, M. D.

FEB 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9-1930

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to Feb 9, 1930, that I last saw h[illegible] alive on Feb 9, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Epilepsy Nephritis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? — ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) E. E. Carman, M. D.

2-10, 1930 (Address) 1701 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL 2/13/30

20 UNDERTAKER Geo. J. Roth & Son ADDRESS 1725 Harford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Dienstbach)

E 53933 HEALTH DEPARTMENT—CITY OF BALTIMORE 10 E 53933

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 800 N. Lakewood Ave (St.) (Ward) 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gloria L. Dienstbach

(a) RESIDENCE NO. 800 N. Lakewood Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 3-1927

7 AGE Years 2 Months 3 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Herman H. Dienstbach

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian C. Schultz

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Herman H. Dienstbach (Address) 800 N. Lakewood Ave

15 Filed FEB 10 1930 C. HAMPSON JONES, M. D., Registrar

B 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1930, to Feb 8, 1930, that I last saw h alive on Feb 7, 1930, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) Weak Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Hearn M. D.

2/9/1930 (Address) 39 S. Harrison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Feb. 11 1930

UNDERTAKER George L. Schwartz ADDRESS 2101 Eutaw Pl.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 53934

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53934

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001

1-PLACE OF DEATH Hebrew Home for Infirm

CITY OF BALTIMORE: (No. Lewindale St. 21-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Lipsitt

(a) RESIDENCE No. Belvedere Greenspring Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Lapsitt

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 60 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant

(Address)

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/10 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb-1-1930, to Feb-10-1930, that I last saw h[illegible] alive on Feb-10-1930, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Feindt, M. D.

2/10 1930 (Address) 2404 Entaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rem Rm

DATE OF BURIAL: 2/10 1930

20 UNDERTAKER: Jack Levis

ADDRESS: 1439 E Balto St

SIGMUND FEINDLATT SUPERINTENDENT

Cor.—10-10-29—A Co.—100 Bks.

E 53935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 ✓

E 53935

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 26-37 Ward)

2-FULL NAME Rebecca Davis

(a) RESIDENCE NO. 711 Lemmon St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1st 1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	36	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pa
(State or country)

PARENTS

10 NAME OF FATHER Samuel Wms

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Clark

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Rachel Hayes
(Address) 620 N Carrollton Ave

Filed FEB 11 1930 H. H. JONES Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

Intoxication (duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 da.

18 Where was disease contracted — If not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. O. Gladden, M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2/11/30

20 UNDERTAKER Samuel A. Stanley & Bro Inc ADDRESS 325 E Balto

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53936

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 53936

1—PLACE OF DEATH

REGISTERED NO. 11-24

CITY OF BALTIMORE: (No. 1003 McCulloh ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leon Morsell

(a) RESIDENCE NO. 1003 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1-1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Birdie Morsell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Edsie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Green
(Address) 1003 McCulloh St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/8/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 19, 1929, to Feb 8, 1930, that I last saw him alive on Feb 7, 1930 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McCard M. D.

Feb 10, 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem — DATE OF BURIAL 2/11/30

20 UNDERTAKER Samuel Stansbury — ADDRESS 728 Bolton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 11 1930

Spec.—1-10-21—M&T—1809 Blks.

E 53937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

30 E 53937

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1712 Brunt St. (WARD) 14-20

2-FULL NAME Polly Bailey

(a) RESIDENCE NO. 1712 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jos Bailey

6 DATE OF BIRTH (month, day, and year): April 1863

7 AGE: Years 56 Months 10 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Hawk Atkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Bessie Bailey

(Address) 1712 Brunt St

Filed FEB 11 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19 29 to Feb. 8th 1930.

that I last saw h alive on Jan 7 1930

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Stomatitis

(duration) yrs. mos 6 da.

CONTRIBUTORY (Secondary) Bronchopneumonia

Diabetes mellitus (duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Elbin, M. D.

(Address) 524 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 2-9-30

20 UNDERTAKER: Hamilton Eastlad — ADDRESS: 916 Pine

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Keagle.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53938

91-002

E 53938

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 512 N Gay ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Keagle

(a) RESIDENCE NO. 512 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. 5 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write this word): Married

5a If married, widowed, or divorced HUSBAND of (or) [redacted] of: Elizabeth Keagle

6 DATE OF BIRTH (month, day, and year): Aug 18th 1857

7 AGE: Years 15 | Months 5 | Days 21/22 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 0 & S

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Keagle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Elizabeth Keagle

(Address) 512 N. Gay St

15 Filed ..... 19.. ..... Registrar

FEB 11 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 10 1930 to July 9th 1930

that I last saw h[illegible] alive on July 9th 1930

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Coronary Thrombosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Asthma

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H W Lemmer M. D.

July 10 1930 (Address) 4905 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 12 1930

20 UNDERTAKER: George Schilling & Sons — ADDRESS: 112 E Monument St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53939 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 53939

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 645 W. Fayette St. WARD 23)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Frazier

(a) RESIDENCE No. 645 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Frazier

6 DATE OF BIRTH (month, day, and year) April 1881

7 AGE	Years	Months	Days 19.	If LESS than 1 day, ... hrs. or ... min.
	48	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Sales. 066

(c) Name of employer mil

9 BIRTHPLACE (city or town) (State or country) Pittsburgh

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pittsburgh Pa.

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburgh Pa.

14 Informant wife

(Address)

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10/30.

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to July 10, 1930, that I last saw h alive on July 8, 1930, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the heart.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis, endocarditis

(duration) 2m. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no.

What test confirmed diagnosis? Hystory of illness

(Signed) J. M. MacMurchy M. D.

, 19 (Address) 2147 Huntingdon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem DATE OF BURIAL Feb 11 1930

20 UNDERTAKER John J. Fahey Sons ADDRESS 1318 Light St

B 1 1930

CAUSE OF DEATH MUST BE PLAINLY WRITTEN, so that it may be properly classified. EXPLANATION OF OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53940

CERTIFICATE OF DEATH

74-001

E 53940

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2838 Oakley ave St. 27-56 Ward)

2-FULL NAME Gertrude Price

(a) RESIDENCE NO. 2838 Oakley ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	N	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Littleton E Price

6 DATE OF BIRTH (month, day, and year) March 10 29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50	10	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home worker
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Ferdinand Hahn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Scheld

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Z Ralph Price
(Address) 3306 Garrison Blvd

Filed FEB 11 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

6

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) C L Lawson

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Med History

(Signed) G C Glades, M. D.

, 19 (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park Cemetery

DATE OF BURIAL Feb 12 1930

20 UNDERTAKER W Warren Kortens

ADDRESS 2235 N

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state C OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 53941

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 308 S. Washington ST. 7-4 WARD)

2—FULL NAME Antoni Dombrowski

(a) RESIDENCE NO. 308 S Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Constantine Dombrowska

6 DATE OF BIRTH (month, day, and year): May 8 1877

7 AGE: Years 52 | Months 9 | Days 2. | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Moulder

(b) General nature of industry, business, or establishment in which employed (or employer): Lacy Company

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Frank Dombrowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: mbronn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Constantine Dombrowska
(Address) 308 S Washington st

15 Filed FEB 14 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10 30

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1930, to Feb 10, 1930, that I last saw h[illegible] alive on Feb 10, 1930, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Feb 10 1930 (Signed) William Weyand M. D.
(Address) 801 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cemetery — DATE OF BURIAL: Feb. 13 1930

20 UNDERTAKER: George A. Weber — ADDRESS: 705 S Amity st

Do not write in the space below, as that is only for property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 53942

CERTIFICATE OF DEATH.

E 53942

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Loudon Av ST 16-66 WARD)

2-FULL NAME Milton E. Hammond Jr.

(a) RESIDENCE NO. 607 Loudon Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 29 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Milton E. Hammond.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Bolinger

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Milton E. Hammond

(Address) 607 Loudon Ave

15 Filed FEB 11 1930 C. H. JONES, M.D. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10 1930

17

I HEREBY CERTIFY, That I attended deceased from 2-10, 1930, to 2-10, 1930,

that I last saw him alive on 2-10, 1930

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Sh. Wissig, M. D.

, 19 (Address) 4000 Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Feb 12 1930

UNDERTAKER

ADDRESS

T. Elmer Ramsburg

Spec.—1-10-21—M&T—1500 Bks.

Hunt

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53943

E 53943

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Rutter ST., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Hunt

(a) RESIDENCE No. 1514 Rutter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced (HUSBAND) of or (WIFE) of: John Hunt

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE: Years 71; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: James Fore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Caroline Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: John F. Hunt

(Address): 1514 Rutter St. City

15 Filed FEB 11 1930 By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Feb 8, 1930, that I last saw her alive on Feb 7, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 2-? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. William Frey, M. D.

2/10, 1930 (Address) 1738 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: 2/11 1930

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Pennsylvania Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53944

CERTIFICATE OF DEATH

E 53944
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1004 W. Franklin St., 18 (Ward)

2-FULL NAME Emily J. Duvall

(a) RESIDENCE NO. Prince George Co. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Duvall

6 DATE OF BIRTH (month, day and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Prince George
(State or country) Co.

PARENTS

10 NAME OF FATHER McKeown

11 BIRTHPLACE OF FATHER (city or town) Prince George
(State or country) Co.

12 MAIDEN NAME OF MOTHER Hannah Parker

13 BIRTHPLACE OF MOTHER Prince George
(State or country) Co.

14 Informant Lucy Rice
(Address) 1004 W. Franklin

15 FILED ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ... yrs. ... mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted If not at place of death? Prince George Co.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.
Feb 13 1930 (Address) Coroner

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington, Md.

DATE OF BURIAL Feb. 15, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 Schroeder St

B 11930

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—5000 Blks.

E 53945

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53945

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Leadenhall St. 23-31 WARD)

2-FULL NAME Sarah Ward

(a) RESIDENCE No. 906 Leadenhall St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Ward

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years: about 28 yrs. Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Norfolk Va.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: George Ward (Address) 906 Leadenhall

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30 1930 to Feb. 8 1930

that I last saw h.e alive on Feb. 8 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Chronic Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine Analysis

(Signed) Dr. Lincoln Calhoun

2/10 1930 (Address) 326 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Ct

DATE OF BURIAL: Feb 11 1930

20 UNDERTAKER: A. L. Brown & Son

ADDRESS: 108 W. Mosley

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53946.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 53946

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 6-9 ST.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William McCoy

(a) RESIDENCE NO. 1619 Orleans St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23, 1852 ?84

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46? or 77 ?	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jake Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Catherine Floyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14

Informant Records of

(Address) Balto. City Hospitals

15

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-6-30

17

I HEREBY CERTIFY, That I attended deceased from 12-1-29, 19, to 2-6-30, 19,

that I last saw h im alive on 2-6-30, 19

and that death occurred, on the date stated above, at 5 A.M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic: Senile Dementia (duration) over 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

2-6, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem

DATE OF BURIAL: 2-11 1930

20 UNDERTAKER: Byron Wright

ADDRESS: 218 McElderry St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53947

188-901 E 53947

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Pa R.R. nr Calverton St. 8-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry H. Gebhardt

(a) RESIDENCE NO. 1529 N Broadway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	37	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Balto City
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Frederick Gebhardt

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Baum

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) City

14 Informant Mrs. Kath. Darsey
(Address) 1529 N. Broadway

15 Filed ..... 19..... Registrar

FEB 11 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/9 1930

17 I HEREBY CERTIFY, That I took charge of the remains deserihed above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
Run over by Pa R.R.
freight train Nr. Calverton

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

2/11 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	2/12 1930
20 UNDERTAKER	ADDRESS
John A Moran	3000 E Balto St

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53948

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53948

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. R45-11

CITY OF BALTIMORE: (No.) 3631 Hineline (St.) (Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theodor C. Hartmann

(a) RESIDENCE NO. 3631 Hineline Rd (St.) WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign born? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29th 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Service Stationer

(b) General nature of industry, business, or establishment in which employed (or employer) Gasoline Station

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Emil Hartmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minna Seite

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clara Seippel
(Address) 2318 Fredk. Ave.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

R 1 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 9/30

17 I HEREBY CERTIFY, That I attended deceased from Feby 8, 1930, to Feby 9, 1930, that I last saw him alive on Feby 9, 1930, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

29 hours (duration)

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Chas. W. Dill, M. D.

2/10. 1930 (Address) 1433 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Feb. 12, 1930
20 UNDERTAKER Chas. W. Dill.	ADDRESS 3709 Fredk. Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53949 E 53949

CERTIFICATE OF DEATH.

REGISTERED NO. C 87

27-52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4804 York Rd St.; (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Josephine O'Melia

(Residence in Baltimore: No. Same as above. St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fm

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Wid

6-DATE OF BIRTH, Jan (Month) 4 (Day), 1852 (Year)

7-AGE, 78 yrs. 1 mos. 7 ds. 6

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Saml P Goors

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emily Linsley

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C. L Mundy

(Address) 4804 York Rd.

15-

Filed C. HAMPSON JONES, M. D. Registrar.

By Asst

B 1 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb (Month) 10 (Day), 1930 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 23 1930, to Feb 10 1930, that I saw h[er] alive on Feb 9 1930, and that death occurred, on the date stated above, at 1245 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) E. J. O'Melia M. D.

, 191... (Address) 4535 York Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Greenmount Cemetery DATE OF BURIAL Feb 12, 1930

20-UNDERTAKER Chas. H. Mause & Son ADDRESS 1811 N. Howard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

E 53950

1—PLACE OF DEATH

REGISTERED NO. 15-58

CITY OF BALTIMORE: (No. 3419 Parkheights Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Ginsberg

(a) RESIDENCE NO. 3419 Parkheights Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Ginsberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman L. Ginsberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lena

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Leurs

(Address) 1439 E. Balto St

15 Filed 1 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1929 to Feb 10th, 1930 that I last saw him alive on Feb 10, 1930 and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(duration) yrs. 11 mos. 10 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) J. M. Chadwick M. D.

, 19 (Address) 2225 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rohrer Mach Rod

DATE OF BURIAL 2/12 1930

20 UNDERTAKER Jack Leurs 1439 E Balto St

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53951

91-002

E 53951

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 10-14 WARD)

2—FULL NAME Anna Heddinger

(a) RESIDENCE NO. Preston + Valley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Dinis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Brennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor
(Address) Preston + Valley St

15 Filed FEB 1 1930 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10th 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 25, 1930, to Feb 10, 1930, that I last saw h.e alive on Feb 9, 1930 and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Senility
Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wolff M. D.

2/11, 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Feb 12, 1930
20 UNDERTAKER	ADDRESS
Rider Weidefeld &	4 Granby Pl

B 1 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 53952 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53952

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1431 Harford Ave ST. 9-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Paul Barrett

(a) RESIDENCE No. 1431 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10th 1929

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Cardiff Md

PARENTS

10 NAME OF FATHER Wm Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cardiff Md

12 MAIDEN NAME OF MOTHER Emilie Combs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Md

14 Informant Mr William Barrett

(Address) 1431 Harford Ave

15 Filed 1 1 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11th 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/11, 1930, to 2/11, 1930, that I last saw him alive on 2/11, 1930, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) — none

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

2/11, 1930 (Address) 733 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL State Ridge Md — DATE OF BURIAL 2/13/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

B 1 T 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks. Dr Maurice Shaver 3300 W North Ave

E 53953

E 53953 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2819 Rayner Ave ST. 668 WARD)

2-FULL NAME Annie L. Hancock

(a) RESIDENCE NO. 2819 Rayner Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of John T. Hancock

6 DATE OF BIRTH (month, day, and year) Aug 22nd 1846

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
83	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo. H. Pope

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ann Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant G. F. Hancock
(Address) 2819 Rayner Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1930, to Feb. 9, 1930, that I last saw h[illegible] alive on Feb. 8, 1930, and that death occurred, on the date stated above, at 6:40 A.M.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis of heart.

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shaver, M. D.

2/10, 1930 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 2/12/1930

UNDERTAKER Wm Cook — ADDRESS 127 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 11 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 53954 Stigbolowicz CERTIFICATE OF DEATH 90 E. 53954

1-PLACE OF DEATH

City of Baltimore: (No. 3012 Cold Spring Lane Ward) 15-58

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna E Vincent Stigbolowicz

(a) RESIDENCE NO. 3012 Cold Spring Lane Ward 6th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mrs Stigbolowicz — William Vincent

6 DATE OF BIRTH (month, day, and year) Apr 11th 1861

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
68	10	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Hazelton Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hannah Hazard
(Address) 3012 Cold Spring Lane

15 Filed 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 1 mos. 1 da.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. 1 da.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Med. History

(Signed) G. Hampson Jones, M. D.

, 19 (Address) 1436 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Pa — DATE OF BURIAL 2/12/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

11 1930

Cor.—10-10-29—A Co.—100 Bks.

E 53955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

19 E 53955

1-PLACE OF DEATH

City of Baltimore: (No. 604 W. Saratoga St. 4-25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Conklin

(a) RESIDENCE NO. 604 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment In which employed (or employer) 080
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) U.S.A

PARENTS

10 NAME OF FATHER Charles Conklin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) U.S.A.

12 MAIDEN NAME OF MOTHER Margaret Kearns

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant E. A. Dowling
(Address) 62 Norman Ave Brooklyn

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

B 1 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull.

Homicide

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Broadway Market

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene Zeller M. D.

1/11 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Brooklyn New York	Feb 11 1930
20 UNDERTAKER	ADDRESS
John C. Miller 2433 E	Oliver St

NOTICE: MARK LABEL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53956

CERTIFICATE OF DEATH.

REGISTERED NO. E 53956

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) House of Good Shepherd ST. Virginia Ave & Collins ave WARD)

2-FULL NAME Viola Bartlett

(a) RESIDENCE NO. Vincent & Collins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) age 16

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Swimming Chorus

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Edenton Md

PARENTS

10 NAME OF FATHER Charles Bartlett.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant (Address) House of Good Shepherd Mount & Stafford Ave B.

15 Filed ... 19 ... By ... Registrar

C. E. THOMSON JONES, M. D.

FEB 11 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10th, 1930, to Feb 10th, 1930, that I last saw h[illegible] alive on February 10th, 1930 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Pulmonary embolism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) J. A. Copeland, M. D.

Feb 11th 1930 (Address) 1300 Vincent St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	2/12/1930
20 UNDERTAKER	ADDRESS
J. J. Fahey & Sons	1918 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53957

HEALTH DEPARTMENT—CITY OF BALTIMORE

25-003 E 53957

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Mercy Hospital ST. 17-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Royal Stokes M.D.

(a) RESIDENCE NO. 1639 E. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 5 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Dunderdale Stokes

6 DATE OF BIRTH (month, day, and year) Aug 21 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore City (State or country) Md

PARENTS

10 NAME OF FATHER Bradley T. Stokes

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary L. Whitney

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md. (State or country)

14 Informant Wm H. Stokes

(Address) 1639 E. Calvert

15 Date received FEB 12 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from February X, 1930, to Feb 10, 1930, that I last saw h... alive on Feb 10, 1930 and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Psittacosis

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Balto. City Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) David Turner, M. D.

2/11, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	2-12 1930
20 UNDERTAKER	ADDRESS
Henry W. Jenkins Sons &	Orchard & McCulloh

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53958 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53958

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1816 N. Wolfe ST. 8-17 (WARD)

2-FULL NAME Jane Shaw

(a) RESIDENCE NO. 1816 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Shaw

6 DATE OF BIRTH (month, day, and year) June 17th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	70	7 0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Henry Lea

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Jane Moreton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant J. Shaw (Address) 1816 N. Wolfe St.

15 Filed DEC 12 1930, 19 Reg'r Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 10th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 26 29, to Feb 10 30, that I last saw h[illegible] alive on Feb 9, 1930, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease of Heart -

Arterio Sclerosis -

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Emmert, M. D.

(Address) 622 N. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery DATE OF BURIAL 2/12/1930

20 UNDERTAKER E. J. Fanning & Son - 1938 E. Lafayette Ave ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B

Spec.--8-16-29--L. F. S.--100 Bks.

E 33682 E 53959 — E 53959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Donald Bubes

(a) RESIDENCE NO. Sparrows Point ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2 1/2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) MD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Va —

PARENTS

10 NAME OF FATHER Clifton Bubes

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va

12 MAIDEN NAME OF MOTHER Alice Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 12 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 11 1930

17 I HEREBY CERTIFY That I attended deceased from Feb-3, 1930, to Feb-11, 1930, that I last saw h.er alive on Feb-11, 1930 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Benj. E. Hodges, M. D.

Feb 11, 1930 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Morgan Town W Va	2/13/30
20 UNDERTAKER Jos. Lahrens	ADDRESS 224 Ruxy

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53960

E 53960

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2602 Jefferson ST. 7-10 WARD)

2-FULL NAME Christina Dethen

(a) RESIDENCE NO. 2602 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of the Late Frederick Dethen

6 DATE OF BIRTH (month, day, and year) Dec 24-1837

7 AGE	Years	Months	Days 16	If LESS than 1 day, hrs. or min.
	92	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dobrath

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Agnes Holzer

(Address) 2602 Jefferson St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

By

FEB 12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/10/30 19

17

I HEREBY CERTIFY, That I attended deceased from 1/10/30, 19..., to 2/10/30, 19...,

that I last saw h[illegible] alive on 2-9-30, 19...,

and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Herrman, M. D.

2/10/30 (Address) 1706 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: Feb 14 1930

UNDERTAKER: Mrs C. Fullerton

ADDRESS: 2334 Jefferson St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-92 53961

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1533 N. Caroline ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Byrne

(a) RESIDENCE NO. 1533 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 92 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Byrne

6 DATE OF BIRTH (month, day, and year) 2/15-1837

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
92	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Shoe Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Richard Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Murray L Byrne

(Address) 1533 N Catolin St

15 Filed ..., 19.. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11, 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb 11 '30, 1 am 30, to Feb 11, 1930, that I last saw him alive on Feb 11, 1930 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis & hypertension (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W Sanderson, M. D.

, 19 (Address) 1710 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	2/15 1930

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Avenue

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 12 1930 HARRISON JONES M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53962

CERTIFICATE OF DEATH

E 53962

1—PLACE OF DEATH

REGISTERED NO. 161

CITY OF BALTIMORE: (No. 1815 Aisquith ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Doris Lorrant Ripple

(a) RESIDENCE NO. 1815 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11. 1930

7 AGE Years	Months	Days	If LESS than 1 day 10 hrs. or min.
—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Rippel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Hilda Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Frank Rippel

(Address) 1815 Aisquith St.

15 Filed FEB 12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11 1930. to Feb 11 1930.

that I last saw h[illegible] alive on Feb 11 1930

and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J W Kenney, M. D.

19 (Address) 1512 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Feb 12 1930
20 UNDERTAKER	ADDRESS
Geo J Ruth	1735 Hayford ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

233643 E 53963 — 129 ✓ E 53963

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 24-33

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. ____ WARD ____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel H. F. Mortimer

(a) RESIDENCE NO. 624 E Clement ST., WARD F
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Mortimer

6 DATE OF BIRTH (month, day, and year) ~~Thursday~~ May 5 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldering Wood 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) NEW YORK ~~Md~~

PARENTS

10 NAME OF FATHER Thomas H Mortimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Del.~~

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 12 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930, to Feb 9, 1930, that I last saw him alive on Feb 9, 1930, and that death occurred, on the date stated above, at 10 25 p m.

The CAUSE OF DEATH* was as follows: Pulmonary Edema 2 days

Contrib Arterio & arteriosclerosis

~~Hypertension~~

Chronic nephritis

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary) Hypertension

(duration) 5 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alexander Craton, M. D.

2/10, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: OAK LAWN CEMETERY — DATE OF BURIAL: FEB 12 1930

20 UNDERTAKER: John H. Denny — ADDRESS: 715 LIGHT ST

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 12 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53964

CERTIFICATE OF DEATH

90 ✓

E 53964

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 442 N. Gay St. St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Schaefermann.

(a) RESIDENCE NO. 442 N. Gay. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ~~mos.~~ ~~da.~~ How long in U. S., if of foreign birth? 46 yrs. mos. da.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	67	-----	-----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith.
(b) General nature of industry, business, or establishment in which employed (or employer) 006
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Elisabeth Seitzel, (cousin)
(Address) Harford Road.

15 Filed FEB 12 1930 E. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 7, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

2/12 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Feb. 13 1930

20 UNDERTAKER: Geo. W. Whittle ADDRESS: 2700 Edmondson

90

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53965

CERTIFICATE OF DEATH

129 ✓ E 53965

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 914 S. Linwood ave WARD 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Griffin

(a) RESIDENCE NO. 914 S. Linwood ave ST. 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of the late George Griffin

6 DATE OF BIRTH (month, day, and year) Aug. 2nd 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Firmin

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Wiegand

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs George Lewis
(Address) Park Point Md.

15 Filed ..., 193.. C. H. JONES, M. D.
Registrar

FEB 12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to Feb 10, 1930, that I last saw h er alive on Feb - 10 -, 1930 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

chr. Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) chr. Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) N. J. Davidson, M. D.

19 (Address) 3035 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 14 1930
20 UNDERTAKER Lilly & Sons Inc	ADDRESS 4032 Wash St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

233743 ME 53966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 ✓ E 53966

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Farley

(a) RESIDENCE NO. 1610 Normal ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph

6 DATE OF BIRTH (month, day, and year) May 18-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N.W. '27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Henry Schriebes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Gretz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed BIT 2 1930 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 10, 1930, that I last saw her alive on Feb 10, 1930 and that death occurred, on the date stated above, at 950 p m.

The CAUSE OF DEATH* was as follows:

Diabetic Acidosis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Alexander Peeta, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb 13 1930
20 UNDERTAKER Lilly & Zeiler Inc	ADDRESS 400 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—109 Bks.

53967

HEALTH DEPARTMENT—CITY OF BALTIMORE

53967

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto Md 2407 Mad. ave REGISTERED NO. 129

CITY OF BALTIMORE: (No. 2407 Mad. ave ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mable Harris

(a) RESIDENCE NO. 2407 Mad. ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John Harris

6 DATE OF BIRTH (month, day, and year): 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
20	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Georgia

PARENTS

10 NAME OF FATHER: Burl Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgia

12 MAIDEN NAME OF MOTHER: Rosie Gimble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Georgia

14 Informant: Emma Gibson

(Address) 2407 Madison Ave

15 Filed FEB 12 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10—1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec 20— 1929, to Feb 10— 1930, that I last saw her alive on 2—9— 1930 and that death occurred, on the date stated above, at 11.00 A.M.

The CAUSE OF DEATH* was as follows:

Uterine Neoplasm

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

Pyelitis (duration) 2 mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Micro + Macro Exam

(Signed) J. R. Hopkins, M. D.

19 (Address) 1512 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 12 30
20 UNDERTAKER	ADDRESS
Virginia A Brooks	1403 N. Carey

FEB 12 1930

IMPORTANT—Name of cemetery supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 53968 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53968

CERTIFICATE OF DEATH. 101-00

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave (ST.) 21-31 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin A Jacob

(a) RESIDENCE NO. 1011 Russell St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 11, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	25	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Polisher

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Franklin L. Jacob

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Katie Mackes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Franklin L. Jacob
(Address) 1011 Russell St.

15 Filed FEB 12 1930 C. NELSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1930, to Feb 10, 1930, that I last saw him alive on Feb 10, 1930, and that death occurred, on the date stated above, at 7.40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Paul Cohen, M. D.

(Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbutus Hill Cem — DATE OF BURIAL Feb 13 1930

20 UNDERTAKER C Schlosman & Son — ADDRESS 1034 Fountain

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 53969 HEALTH DEPARTMENT—CITY OF BALTIMORE 15-002 E 53969

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Whitridge Ave ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Anthony

(a) RESIDENCE NO. 327 Whitridge Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. W. Anthony

6 DATE OF BIRTH (month, day, and year) Nov.? 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	3	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. J.

PARENTS

10 NAME OF FATHER John Hennelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winifred Tafe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John J. Hennelly (Address) 327 Whitridge Ave

15 Filed ....., 19.... RMC Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1929, to Feb 9, 1930, that I last saw h.e alive on Feb 5, 1930, and that death occurred, on the date stated above, at 5 55 A m.

The CAUSE OF DEATH* was as follows:

a Paralysis

(duration) ..... yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. D. Hamblen, M. D.

, 19 (Address) 9 E Biddle St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Romini - Va DATE OF BURIAL Feb. 12 1930

20 UNDERTAKER Wm Hickner Sons ADDRESS North x Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53970

CERTIFICATE OF DEATH

90 E 53970

1-PLACE OF DEATH

City of Baltimore: (No. 819 Colvin St. St., 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Nichols.(C)

(a) RESIDENCE NO. 819 Colvin St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	45	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Charles Nichols.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Jane Dickerson.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Morris Nichols.(C)brother
(Address) 819 Colvin St.

15 Filed ... 19 ... Registrar

FEB 12 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 11, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

2/12 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hearse 2 o

20 UNDERTAKER E. Bryon

DATE OF BURIAL Feb 14 1930

ADDRESS 1631 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53971

CERTIFICATE OF DEATH

31 ✓

E 53971

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO.

CITY OF BALTIMORE: (No. 9-18 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F. O'Brien

(a) RESIDENCE NO. 1545 Ensor st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56 55				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank O'Brien

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Reville

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Hospital Records
(Address)

15 Filed FEB 12 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1929, to Feb. 11, 1930, that I last saw him alive on Feb. 11, 1930, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Jas Simmons M. D.

2-11, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Feb. 14, 1930
20 UNDERTAKER	ADDRESS
Edward W. Conklin	424 E. Eager St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53972 129 E 53972

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 20-27

CITY OF BALTIMORE: (No. 1926 W. Lanvale ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elsa Yingling

(a) RESIDENCE NO. 1926 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? - yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 5, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	44	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas B. Yingling

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Snyder

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) West Virginia

14 Informant Mrs. B. Mersell

(Address) 1252 Oates St. N.E. Wash. D.C.

15 FEB 12 1930 C. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10, 1930

17

I HEREBY CERTIFY, That I attended deceased from November, 19 26, to February 11, 19 30,

that I last saw h alive on February 10, 19 30

and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Malignant heart disease and interstitial nephritis

(duration) 3 years. yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) - yrs. mos. ds.

18 Where was disease contracted
If not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical Data

(Signed) Harry C. Clute, M. D.

2-11, 1930 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Feb 13 19 30
20 UNDERTAKER George Smith	ADDRESS 13 E. Hoffman

B OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 53973

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53973

CERTIFICATE OF DEATH

REGISTERED NO. 74

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Rugby Hall apts ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Broome Olives

(a) RESIDENCE NO. Rugby Hall apts. University parkway.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Alma white Olives

6 DATE OF BIRTH (month, day, and year): Aug 3 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Stock Broker.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Charles A Oliver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Broome.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: wife Mrs Wm B Oliver

(Address): Rugby Hall apts

15 Filed ..., 19.. C. HUNTER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/11/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 6th, 1929, to Feb 11th, 1930, that I last saw him alive on Feb 11th, 1930 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Myocardial failure, plus Pulmonary Edema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia. Cerebral Thrombosis (duration) yrs. 6 mos. 5 ds.

18 Where was disease contracted if not at place of death? pneumonia at home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Slight heart & lung sounds

(Signed) Henry Sheppard Jr. M. D.

, 19 (Address) 920 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge cemetery — DATE OF BURIAL: Feb 13 1930

20 UNDERTAKER: George L Smith — ADDRESS: 153 L Hollins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 12 1930

Spec.—8-16-29—L. F. S.—100 Blks.

E 53974 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 53974

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 27-53

CITY OF BALTIMORE: (No.) 507 Edgerale Rd ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Tully Armistead Joynes

(a) RESIDENCE NO. 507 Edgerale Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W	Widowed

5a If married, widowed, or divorced HUSBAND of Mary J Hamilton

6 DATE OF BIRTH (month, day, and year) Dec 7. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steamboat Executive (ret)

(b) General nature of industry, business, or establishment in which employed (or employer) Executive &c

(c) Name of employer B C & A R.R. Co

9 BIRTHPLACE (city or town) (State or country) Onancock Va.

PARENTS

10 NAME OF FATHER Tully Armistead Joynes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Onancock, Va

12 MAIDEN NAME OF MOTHER Sabra Pott Fitchett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Onancock Va

14 Informant Mrs A. M. Shuffey
(Address) 507 Edgerale Road

15 Filed FEB 12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1930 to Feb 12 1930, that I last saw h[illegible] alive on Feb 12 1930 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis & Senility

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Watson Fox Toulson, M. D.

Feb 12. 1930 (Address) Medical Arts Bldg. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Onancock Va — DATE OF BURIAL July 14 1930

20 UNDERTAKER John O. Mitchell & Sons — ADDRESS 19 E Church St Clerk

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 49 E 53975

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2703 Mayfield Ave ST. WARD)

2—FULL NAME Walter B Bruning

(a) RESIDENCE NO. 2703 Mayfield ST., WARD Kentucky
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Bruning

6 DATE OF BIRTH (month, day, and year) May 17 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago

PARENTS

10 NAME OF FATHER Rev David Bruning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Ida Steifel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chicago

14 Informant Rev David B Bruning
(Address) 2703 Mayfield Ave

15 Filed FEB 12 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 10, 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 10, 1930, that I last saw him alive on Feb. 10, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Thyroid Gland

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastatic in Brain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

2/11, 1930 (Address) 1523 N. Wood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem — DATE OF BURIAL Feby 17, 1930

20 UNDERTAKER John Merrick — ADDRESS 208 E Preston St

IMPORTANT—Answer questions carefully and supply data requested. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 53976

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓ E 53976

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1111 Madison ave) (WARD) 11-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Barnes

(a) RESIDENCE NO. 1111 Madison ave ST.
(Usual place of abode)

WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: 71 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: none.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Rebecca Blackstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Annie B. Hutchings

(Address): 1111 madison ave.

15 Filed FEB 12 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 9, 1930, that I last saw h[illegible] alive on Feb 9, 1930 and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Stroke (Paralytic) and Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Exam.

(Signed) G. H. Hall, M. D.

19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Febry 12 1930

20 UNDERTAKER: Samuel T. Hensley

ADDRESS: 578 W Mad[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

FEB 12 1930

Spec.—1-30—M. & T.—250 Blks.

E. 53977 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 53977

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 136 N. Haven ST. 26-37 WARD)

2-FULL NAME Annie M. Wiener

(a) RESIDENCE No. 136 N. Haven ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H. Wiener

6 DATE OF BIRTH (month, day, and year) Mar 21/1885

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
44	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS
10 NAME OF FATHER Frederick Schumm
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Magdalena Kroll
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm H. Wiener
(Address) 136 N. Haven St.

15 Filed FEB 12 1930, 19.. C. ELLIPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to Feb 10, 1930, that I last saw her alive on Feb 10, 1930, and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endomyocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Observation

(Signed) Horace B. Tilghman, M. D.
2/11 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Gem — DATE OF BURIAL Feb 13 19 30

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 53978

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-02

53978

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. ST. 25-32 WARD)

2-FULL NAME Baby Girl Kinsey

(a) RESIDENCE NO. Sinai Hosp. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 2-7-30.

7 AGE: Years — Months — Days 2 — If LESS than 1 day, 42 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Leo. S. Kinsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Filed 1-3-54 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-9 1930

17

I HEREBY CERTIFY, That I attended deceased from 2-7, 1930, to 2-9, 1930.

that I last saw h[illegible] alive on 2-9, 1930,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood in Spinal Fluid

(Signed) Leland Warfield, M. D.

(Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER: Commissioner Health

DATE OF BURIAL 19

ADDRESS

Per [illegible]

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

54

1-2-1930 APK

Spec.—8-16-29—L. F. S.—100 Bks.

2336 80
2 E 53079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 V
E 53079

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Horace Jones -

(a) RESIDENCE NO. 1 8 S - Hallas ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): March 8 1927

7 AGE: 2 Years | Months 10 23 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md -

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Hilda Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records -
(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 12 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4 - 30

17 I HEREBY CERTIFY, That I attended deceased from Feb - 3 , 19 30 , to Feb - 4 , 19 30 , that I last saw him alive on Feb - 4 , 19 30 and that death occurred, on the date stated above, at 1 4 m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar, Rt lung

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? none

(Signed) Benjamin E. Hodges, M. D.

19 (Address) Johns Hopkins Hosp -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS FEB 12 1930

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state C... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION i... important. See instructions on back of certificates.

FEB 12 1930

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53980 90 E 53980

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 8-16

CITY OF BALTIMORE: (No. 1303 N. Milton Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Trenolla

(a) RESIDENCE NO. 1303 N. Milton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George A. Trenolla

6 DATE OF BIRTH (month, day, and year): 3-6-1865

7 AGE: 64 Years 65 | Months 11 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

037

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: John Heil

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Heil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs John Trenolla

(Address): 1303 N. Milton Ave

15 Filed FEB 12 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1925, to Feb 10, 1930, that I last saw him alive on Feb 10, 1930 and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia + Aortic regurgitation (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical tests

(Signed) Elliott Bergwald, M. D.

2/11, 1930 (Address) 1613 Work Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery — DATE OF BURIAL: Feb 13 1930

20 UNDERTAKER: Mary M Wadefield — ADDRESS: 501 E 22 St

MATTER SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 53981

233897

Urol.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 49 E 53981

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph McAneny

(a) RESIDENCE NO. 731 Luzerne St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary

6 DATE OF BIRTH (month, day, and year) 1-15-80

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Neil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Hamil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 12 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-12-30

17

I HEREBY CERTIFY, That I attended deceased from 2-10-, 19 30, to 2-12-, 19 30, that I last saw h~~im~~ alive on 2-12-, 19 30 and that death occurred, on the date stated above, at 1 25 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder, Urinary.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure,

(duration) yrs. mos. 10 ds. min

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 12. 1930

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E C Danner, M. D.

, 19 (Address) Johns Hopk. Hosp Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnstown Pa	Feby 14 1930
20 UNDERTAKER	ADDRESS
Geo M Enos Jr	811 N Wolfe

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53982 ✓ E 53982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 N. Dallas ST. 6-9 WARD)

2-FULL NAME Richard Johnson

(a) RESIDENCE NO. 427 Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 14-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
14	10		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Estella Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Estella Johnson (Address) 427 Dallas St

Filed FEB 12 1930, 19 C. H. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1930, to Feb 10, 1930, that I last saw him alive on Feb 10, 1930, and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Acute Croupous Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. L. Gillen, M. D.

2-10, 1930 (Address) 508 Somerset

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	2-12 1930
20 UNDERTAKER	ADDRESS
Daniel Easter	916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 53983 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto. City Hospitals REGISTERED NO. 90

CITY OF BALTIMORE: (No. 24-34 ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine McGuirk

(a) RESIDENCE No. 1307 Battery Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Dec. 23, ~~1869~~ 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72 yr	1	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS
10 NAME OF FATHER Andy McGuirk
11 BIRTHPLACE OF FATHER (city or town) (State or country) ~~Unknown~~ Pa
12 MAIDEN NAME OF MOTHER Mary Ann Fogle
13 BIRTHPLACE OF MOTHER (city or town) (State or country) ~~Unknown~~ Pa

14 Informant Records of Balto. City Hospitals
(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10-30

17 I HEREBY CERTIFY, That I attended deceased from 2-8-30, 19..., to 2-10-30, 19...,
that I last saw her alive on 2-10-30, 19...,
and that death occurred, on the date stated above, at 11:30 P.m.

The CAUSE OF DEATH* was as follows:
Myocarditis, chronic ? acute
(duration) ..... yrs. 3 mos ..... ds.
CONTRIBUTORY (Secondary) Hypertension? Arteriosclerosis ?
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Harvie McKean, M. D.
2-11, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington, Del — DATE OF BURIAL 2-12-1930

20 UNDERTAKER [illegible] — ADDRESS [illegible]

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 12 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53984

CERTIFICATE OF DEATH

90 E 53984

21-28

1-PLACE OF DEATH

City of Baltimore: (No. Scott & McHenry Sts. St., 21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jesse M. Buffington.

(a) **RESIDENCE NO.** 1448 Nicomico. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. —mos.—da. How long in U. S., If of foreign birth? yrs. mos. da.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married.

5a If married, ~~widowed, or divorced~~
HUSBAND of
~~(or) WIFE of~~ Anna M. Buffington.

6 DATE OF BIRTH (month, day, and year) June 2. 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	59	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machine Hand. (3)
(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett & Hayward.
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Anna M. Buffington. (wife)
(Address) 1448 Nicomico St.

15 Filed ...19..
C. HAMPSON JONES, M. D. Registrar.
By

B 12 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 10, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Arterio sclerosis.

(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

2/12. 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ganeytown Md.	Feby 13 1930
20 UNDERTAKER Liston P. Fassbaugh	ADDRESS 21 20 St Paul

Spec.—8-16-29—L. F. S.—100 Bks.

E 53985

HEALTH DEPARTMENT—CITY OF BALTIMORE

45

E 53985

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 19-27

CITY OF BALTIMORE: (No. University Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace A. Dittelmar

(a) RESIDENCE NO. 341 S. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence L. Howard (nee Hayes)

6 DATE OF BIRTH (month, day, and year) Feb. 16, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Department of Street

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Dittelmar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Florence L. Dittelmar

(Address) 341 S. Gilmor St

15 2 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25/30.

17 I HEREBY CERTIFY, That I attended deceased from 2/7, 1930, to 2/25, 1930, that I last saw h alive on 2/25, 1930. and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid colon.

(duration) autumn. yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anaemia.

(duration) autumn. yrs. mos. ds.

18 Where was disease contracted if not at place of death? autumn

Did an operation precede death? yes Date of 2/8/30

Was there an autopsy? no.

What test confirmed diagnosis? Clin & Operation

(Signed) Henry F. Helrich, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Feb. 13 1930

20 UNDERTAKER: Harry A. Deitzler, 410 — ADDRESS: Edmondson Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

B

Spec.—1-10-21—M&T—1500 Blks.

E 53986

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53986

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph Hospital (ST.) 13-52 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Louise Gayhardt

(a) RESIDENCE No. 1222 Union Ave ST., ... WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 9 1929

7 AGE: Years — Months 5 — Days 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Robert H. Gayhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Anna Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Robert H. Gayhardt

(Address) 1222 Union Ave

Filed FEB 13 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1930

17

I HEREBY CERTIFY, That I attended deceased from 2-11-30, 19..., to 2-12-30, 19...,

that I last saw h[illegible] alive on 2-12-30, 19...,

and that death occurred, on the date stated above, at 2.05 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Physical & Post mortem

(Signed) H. H. Hundley M. D.

, 19 (Address) 1222 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden — DATE OF BURIAL: Feb 13 1930

UNDERTAKER: Thanower & Son — ADDRESS: 967 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53987

E 53987

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 759 Bartlett Ave 9-46 St., Ward)

2-FULL NAME Dora Benner

(a) RESIDENCE NO. 759 Bartlett Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Benner

6 DATE OF BIRTH (month, day, and year) Nov 28 1876

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
53	3	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pa.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Mary Johnson
(Address) 759 Bartlett ave

15 Filed ... 19... C. HAMPTON JONES, M. D., Registrar

FEB 13 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Dilatation
(Cause undetermined)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John Cullen, M. D.

2/12/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Comwlbowdle Pa	2-14 1930
20 UNDERTAKER	ADDRESS
E + B Harle	115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53988

CERTIFICATE OF DEATH

129

E 53988

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 1138 Cleveland St. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Ruskell

(a) RESIDENCE NO. 1138 Cleveland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry L. Ruskell

6 DATE OF BIRTH (month, day, and year): Nov 14 1877

7 AGE: Years 52 | Months 3 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Andrew Stickel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Francis Nagle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Harry L Ruskell
(Address) 1138 Cleveland St

15 Filed FEB 13 1930 E. H. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-11-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Feb 11, 1930, that I last saw her alive on Feb. 10, 1930 and that death occurred, on the date stated above, at 2:13 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis (Interstitial)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Anthony V. Bruckner, M. D.

2/12, 1930 (Address) 37 S Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: 2-14 1930

20 UNDERTAKER: Bernard C. Harle

ADDRESS: 1000 S Paca St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53989

CERTIFICATE OF DEATH

E 53989

REGISTERED NO. 167-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 17 N. Gilmor St. 19-27 Ward)

2-FULL NAME August Teufer

(a) RESIDENCE NO. 17 N. Gilmor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	2+ Lite	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11, 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71	10	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Meat Cutter
(b) General nature of industry, business, or establishment in which employed (or employer): 013
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Gustav Teufer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Julius Teufer
(Address) 2724 Pleasant St.

15 Filed ..... 19 ..... C. HARRISON JONES M. D. Registrar

FEB 13 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by
Illuminating gas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

2/12 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Feb 13 1930
UNDERTAKER: For Joesdens Son	ADDRESS: 2172 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

E 53990

CERTIFICATE OF DEATH.

E 53990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1501 N. Wolf St. 8-17 Ward)

2-FULL NAME Frederick W. Schmainy.

(a) RESIDENCE NO. 1501 N. Wolf St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Schmainy

6 DATE OF BIRTH (month, day, and year): June 26/1872

7 AGE: Years 57 Months 7 Days 16 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 036

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph Schmainy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Mamie Schmainy. 1501 N. Wolf St.

FEB 13 1930

15 Filed 19 H. M. [illegible], M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st 1929, to Feby 11- 1930, that I last saw h.. alive on Feby 11- 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH was as follows:

Cirrhosis of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Thomas H. Wagner, M. D.

2/12, 1930 (Address) 14 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial Feb 14 1930

20 UNDERTAKER: Frank A. Fink ADDRESS 915 N. Gay St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53991

CERTIFICATE OF DEATH

185 E 53991

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 36-2 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herman Heimiller.

(a) RESIDENCE NO. 207 S. Highland Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Widower.

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (~~or WIFE of~~) Catherine Heimiller.

6 DATE OF BIRTH (month, day, and year) February 5, 1840

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	90	0	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Policeman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER John Heimiller.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Jaeger.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant William Heimiller. (nephew)
(Address) 4612 Springdale Ave.

15 Filed ..., 19... [illegible] Registrar

FEB 13 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Femur.

Occicental Fall on the ice.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? N. E. cor Pratt & Light

Did an operation precede death? Date of January 21, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Heinhardt, M. D.

2/12 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Feby 14 1930
20 UNDERTAKER George Schilling & Sons	ADDRESS 1122 E Monument

Spec.—2-29-28—L. F. S.—500 Blks.

E 53992

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 ✓ E 53992

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Balto md. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Stokes

(a) RESIDENCE NO. 1706 E. Madison St., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-13-77

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Frank Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records
(Address) Balto City Hosp

15 Filed FEB 13 1930 19 C. HAMPTON JONES, M. D. Registrar
Ref. Reg

B 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11-30

17 I HEREBY CERTIFY, That I attended deceased from 2-1-, 1930, to 2-11-, 1930, that I last saw h[illegible] alive on 2-10-, 1930, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis
Chronic Myocarditis

Broncho Pneumonia (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) & Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy findings

(Signed) Mary F. Gilmartin M. D.

2/12/1930 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Feb. 14, 1930

20 UNDERTAKER Mrs. Ida Snowden — ADDRESS 408 E Madison St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 53993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 53993

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 16-37 Ward)

2-FULL NAME Babette Michelow

(a) RESIDENCE NO. 915 N Lehigh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
about 65				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ger.
(State or country)

PARENTS

10 NAME OF FATHER Kezell

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ger.
(State or country)

14 Informant Records of Balto. City Hospital
(Address)

15 Filed FEB 13 1930 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Abscess Lung - Pt. E.
Broncho Pneumonia Emphysema

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Yes Date of Jan 2/30

Was there an autopsy? By Hospital

What test confirmed diagnosis? Autopsy

(Signed) G E Blades, M. D.

, 19 (Address) 423 N Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthias Cem

DATE OF BURIAL Feb. 14 1930

20 UNDERTAKER Jos. J. Mer 156 N. Eutaw

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53994

CERTIFICATE OF DEATH

31 V

E 53994

REGISTERED NO. 13-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2409 Francis ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Collins

(a) RESIDENCE NO. 2409 Francis ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Collins

6 DATE OF BIRTH (month, day, and year) April 22 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md

PARENTS

10 NAME OF FATHER Joseph Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susie Linder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Fattie Motor

(Address) 2409 Francis

15 Filed FEB 13 1930 HAYDON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1929 to Feb 12, 1930 that I last saw h alive on Feb 11, 1930 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 5 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray & Sputum

(Signed) H. H. Hatcher M. D.

2/17, 1930 (Address) 1 W Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Chapel West Rivers Md.	Feb. 16 1930
20 UNDERTAKER	ADDRESS
Sam'l H. Chase & Son	1405 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 53995 HEALTH DEPARTMENT—CITY OF BALTIMORE E 53995

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1952 Sponson St. (St.) 25-72 (Ward)

2-FULL NAME Louis Schwemmer Sr.

(a) RESIDENCE NO. 1952 Sponson St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence V. Schwemmer.

6 DATE OF BIRTH (month, day, and year) Nov. 5-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Labor. Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Schwemmer Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Pickles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Florence V. Schwemmer.

(Address) 1952 Sponson St.

Date FEB 13 1930 C. HAYWOOD JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1930

17

I HEREBY CERTIFY, That I attended deceased from Feby 8 1930. to Feby 10 1930.

that I last saw h[illegible] alive on Feby 10 1930

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) Dr. M. Kieffer, M. D.

Feb 13 1930 (Address) 1454 Hart Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. DATE OF BURIAL Feb. 13. 1930.

20 UNDERTAKER Charles J. Schwob's ADDRESS 505 N. Monroe St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53996

CERTIFICATE OF DEATH.

90 ✓

E 53996

1-PLACE OF DEATH Balto. City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 22-30 ST. WARD)

2-FULL NAME James D. Willson

(a) RESIDENCE NO. 426 W. Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec. 17, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer T. Cotman

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Dennis Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mahala Onnelf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed FEB 13 1930 , 19 H. Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10-30

17 I HEREBY CERTIFY, That I attended deceased from 10-17-29, 19..., to 2-10-30, 19...,

that I last saw h... alive on 2-10-30, 19...,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic & acute

Hypertension (duration) ... yrs. 18 mos. ... ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren M. McLaw, M. D.

2-11, 19 30 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion St

DATE OF BURIAL FEB 14 1930

20 UNDERTAKER S. L. Brown & Son

ADDRESS 108 W. Monday

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53997

CERTIFICATE OF DEATH

101-001

E 53997.

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 812 China ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Armstrong -

(a) RESIDENCE NO. 812 China ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. + mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Armstrong

6 DATE OF BIRTH (month, day, and year) — 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	+		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil War Vet

(b) General nature of industry, business, or establishment in which employed (or employer) Veteran Last war

(c) Name of employer Seaman

9 BIRTHPLACE (city or town) (State or country) West Island Maryland

PARENTS

10 NAME OF FATHER Alec Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Island Maryland

12 MAIDEN NAME OF MOTHER Charlotte Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Island Maryland

14 Informant Sarah Ringgold

(Address) 812 E China St

15 Filed FEB 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11/30

17

I HEREBY CERTIFY, That I attended deceased from 2/4, 1930, to 2/11, 1930, that I last saw h alive on 2/10 40 1930 and that death occurred, on the date stated above, at 12 a, m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? none -

What test confirmed diagnosis? none

(Signed) David Francken, M. D.

2/11, 1930 (Address) 1222 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U S National	Feb 14 1930
20 UNDERTAKER	ADDRESS
J. L. Brown & Son	108 W. Montg

mation should be entered, as stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53998 | CERTIFICATE OF DEATH. | 139 E 53998

1-PLACE OF DEATH St Joseph Hospital | REGISTERED NO. 5778

CITY OF BALTIMORE (No.) Eutaw & Church St. | WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Fannie Reed

(a) RESIDENCE NO. 5217 York ST., Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 11 mos. √ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year) March 6 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	√	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dress Maker 69

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George W. Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D. C.

12 MAIDEN NAME OF MOTHER: Fannie Rehleder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York U. S.

14 Informant: Miss Famil J. Reed

(Address) 5217 York Road

15 Filed FEB 13 1930 E. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-11 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-6-30, 19 , to 2-11-30, 19 ,

that I last saw h[illegible] alive on 2-11-30, 19

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Fibroid Uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pancytic Ileus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2-7-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible] M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery | DATE OF BURIAL: Feb 14 1930

20 UNDERTAKER: Chas. H. Black | ADDRESS: 142 W. North ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 53999

CERTIFICATE OF DEATH

170 ✓

E 53999

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Rear of 1516 Hollins St., 19-28 Ward)

2-FULL NAME John E. Kavanaugh

(a) RESIDENCE NO. 1516 Hollins St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1871

7 AGE: Years 58 | Months 7 | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Linotype Operator
(b) General nature of industry, business, or establishment in which employed (or employer): Printing
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER John J Kavanaugh

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Sarah A Burke

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Griffith Covington
(Address) 4125 Belair Rd

15 Filed ..... 19.. C. HARRISON JONES, Registrar
FEB 13 1930 By ....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Pistol shot in head -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What lesl confirmed diagnosis?

(Signed) Chas H Brooke M. D.

2/12. 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rod Cathedral Cemetery — DATE OF BURIAL 2/14 1930

20 UNDERTAKER: Fred. A. Krause & Son — ADDRESS 703 E Hoffman St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

E 54000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001

E 54000

1—PLACE OF DEATH Franklin Square Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 15-21 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chin - Tai - Yee

(a) RESIDENCE NO. 1623 N. Gilmore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Chinese	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry Business

(b) General nature of industry, business, or establishment in which employed (or employer) at 1623 N Gilmor st

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) China

PARENTS

10 NAME OF FATHER Chin Shon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) China

12 MAIDEN NAME OF MOTHER Yee Shee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) China

14 Informant George Chin
(Address) 112 Park ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

FEB 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb-7- 1930, to Feb. 9 1930,

that I last saw h alive on Feb. 9 1930

and that death occurred, on the date stated above, at 4 05 A.m.

The CAUSE OF DEATH* was as follows:

Peritonitis
Incarcerated Hernia - with
gangrenous gut

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Inguinal Hernia - Left

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Yes Date of Feb. 7, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms - operative findings

(Signed) M. B. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Feb 13 1930

20 UNDERTAKER John F Denny — ADDRESS 15 E 14 St

WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY in years, months and days. If LESS than one day, hours or minutes should be carefully supplied. mation

E 54001 CERTIFICATE OF DEATH 179 E 54001

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 3808 Glenayle St. 27-55 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. C. Danglebis

(a) RESIDENCE NO. 3808 Glenayle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret A Danglebis

6 DATE OF BIRTH (month, day, and year): Jan 30 - 1844

AGE: Years 86 Months Days 17

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(r) Name of employer: —

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: William Danglebis

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Agnes Boyd

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Mrs J J Norris

(Address) 3808 Glenayle

FEB 13 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 12, 1929, to Feb 12, 1930, that I last saw him alive on Feb 10, 1930, and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) Louis Blumgart, M. D.

Feb 12 1930 (Address) 720 St. Paul Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: Feb 15 1930

20 UNDERTAKER: William H Shuman — ADDRESS: 4130 Edmondson

CAUTION—WRITE PLAINLY. All items must be carefully supplied. AGE should be carefully stated. Exact statement of DATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54002

101-001 ✓

E 54002

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2511 E Chase St. 8-12 WARD)

2—FULL NAME Mildred Travers

(a) RESIDENCE NO. 2511 E. Chase ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3, 1929

7 AGE — Years: — Months: 4 — Days: 9 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ....

(b) General nature of industry, business, or establishment in which employed (or employer): ....

(c) Name of employer: ....

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Lester Travers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Myrtle Kusterer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Lester Travers

(Address) 2511 E. Chase

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-12-1930

17 I HEREBY CERTIFY, That I attended deceased from 2-11-, 1930 to 2-12, 1930

that I last saw h[illegible] alive on 2-12, 1930

and that death occurred, on the date stated above, at 9-15 P. m.

The CAUSE OF DEATH* was as follows:

acute Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary): acute Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. Demarest, M. D.

2-12, 1930 (Address) Medical arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel

DATE OF BURIAL: Feb 13 1930

20 UNDERTAKER: Frank V. Pepitone

ADDRESS: 2[illegible]2 Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

E 54003 — **CERTIFICATE OF DEATH** — **E 54003**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. General Hospital ST. 15-63 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bernice Stanton

(a) RESIDENCE NO. 3924 Belvidere Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Mrs H Stanton

6 DATE OF BIRTH (month, day, and year) 1/19/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Wm Head

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Bernice Strange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Hospital Records (Address)

15 [illegible] 19 HAMPTON JONES M. D. Registrar

FEB 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11/30

17 I HEREBY CERTIFY, That I attended deceased from 2/7, 1930, to 2/11, 1930, that I last saw h[illegible] alive on 2/11, 1930 and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronch-pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hugo A Freudenberg M. D.

2/13/30, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chattanooga Tenn	Feb 13 1930
20 UNDERTAKER Jos Joerndt & Son	ADDRESS 2178 Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E 54004

CERTIFICATE OF DEATH

E 54004

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 W. Franklin ST. 20-27 WARD)

2—FULL NAME John A. Reitz

(a) RESIDENCE NO. 1806 W. Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 7 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

3a If married, widowed, or divorced, HUSBAND of (or) WIFE of Louisa C. Bauer

6 DATE OF BIRTH (month, day, and year) June 17-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	64	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Highways Dept

(c) Name of employer City Balto

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Reitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa E. Reitz
(Address) 1806 W. Franklin St

15 [illegible] C. H. [illegible] ES, M. D.
Registrar

JAN 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 11-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 7/1930 to Feb 11 1930

that I last saw h[illegible] alive on Feb 10 1930

and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Lung Hemorrhage
Arterio Sclerosis
Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia
Senile pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) A. C. Hamill M. D.

2/13/30 (Address) 1944 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Feby 14 1930

20 UNDERTAKER Harry W. Eblen

ADDRESS 1944 W. North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54005 E 54005

CERTIFICATE OF DEATH.

101-01

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 S. Bethel St. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Webb

(a) RESIDENCE. No. 324 S. Bethel St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Trett

6 DATE OF BIRTH (month, day, and year) Mar. 15 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	32	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer Lord Heath

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William E. Trett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Edgefield S.C.

14 Informant Bertha Trett (Address) 324 S. Bethel st.

15 Filed FEB 13 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 12 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb. 8th, 1930, to Feb 12th, 1930, that I last saw him alive on 11th, 1930, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumococcus Toxemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wimmer, M. D.

19 (Address) 308 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Feb 15 1930
20 UNDERTAKER Theodore E. White	ADDRESS 113 S. Wolfe st.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

155

E 54006

1—PLACE OF DEATH

REGISTERED NO. 16-67

CITY OF BALTIMORE: (No. 3005 Pulaski ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F Baird

(a) RESIDENCE NO. 3005 Pulaski ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma V Baird

6 DATE OF BIRTH (month, day, and year) March 29 56

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B & O R. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) R R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Baird

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Agle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Mrs Emma V Baird

(Address) 3005 Pulaski

15 Filed FEB 13 1930 Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 30

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1929, to Feb 11, 1930, that I last saw h alive on Feb 11, 1930 and that death occurred, on the date stated above, at 1 20 p m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of leg & foot (over)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Septic poisoning

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of Jan 17-1930

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Emma E Todd, M. D.

2/12, 1930 (Address) 735 N Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Feb 13 1930

20 UNDERTAKER D. W. M Roxton

ADDRESS 2238 W North

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

FEB 13 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54007 — 91 — 74-001 ✓ — E 54007

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1039 Fulton Ave ST. 16-22 WARD)

2-FULL NAME Laura Ingraham

(a) RESIDENCE NO. 1039 Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Ingraham

6 DATE OF BIRTH (month, day, and year) Nov 1/1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Geo Wilkinson
(Address) 3307 Beverly Rd

15 Filed FEB 15 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1st, 1930, to Feb. 12th, 1930, that I last saw h[er] alive on Feb. 11th, 1930 and that death occurred, on the date stated above, at 4 30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Followed by Hemiplegia

..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. Emmett Hellenus, M. D.

Feb. 12, 1930 (Address) 1900 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Feb 14, 1930

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 ✓

E 54008

CERTIFICATE OF DEATH

E 54008

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST 3-5 WARD)

2—FULL NAME Baby Chiapparelli

(a) RESIDENCE NO. 905 Lawn St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balt. Md.

PARENTS

10 NAME OF FATHER: Jerry Chiapparelli

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Matilda Corvella

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt. Md.

14 Informant: Herbert F. Faust

(Address)

15 Date: 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-8, 1930, to 2-12, 1930, that I last saw her alive on 2-12, 1930 and that death occurred, on the date stated above, at 5:25 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Herbert F. Faust, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 13, 1930
20 UNDERTAKER: Waddell & Keppel	ADDRESS: 300 E Colvin

FEB 13 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54009

CERTIFICATE OF DEATH.

129 E 54009

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 E. Chase St ST. 8-13 WARD)

2-FULL NAME Martha Jones

(a) RESIDENCE No. 1913 E. Chase St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Denwood Jones

6 DATE OF BIRTH (month, day, and year): Nov 30, 1839

7 AGE: Years 90 Months 3 Days 12 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Baillie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Harriett Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Easton Talbot Md

14 Informant: James D Jones

(Address): 1912 E. Chase St

15 Filed FEB 13 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930; to Feb 11, 1930, that I last saw h[illegible] alive on Feb 11, 1930, and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Nephritis

(duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Hays M. D.

Feb 12, 1930 (Address) 2065 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Feb. 14 1930

20 UNDERTAKER: Robt. J. Turner

ADDRESS 1442 N Broadway

Spec.—8-16-29—L. F. S.—100 Blks.

E 54010

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54010

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital

REGISTERED NO. 1357

CITY OF BALTIMORE: (No. Lombard & Green ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pansy Leaf

(a) RESIDENCE NO. 3677 Ash St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: W. H. Leaf.

6 DATE OF BIRTH (month, day, and year): June 24-1887

7 AGE: Years 42 | Months 7 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife.

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John L. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Aggie Shaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: William F. Leaf

(Address): 3677 Ash St.

15 Filed: 2/13/1930 C. HAMPSON JONES, M. D. Registrar

By: ACD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 12/30.

17

I HEREBY CERTIFY, That I attended deceased from ~~Feb~~ Jan 17 1930, to Feb 12, 1930,

that I last saw her alive on Feb 12, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Rupture of peritonsilar abcess with aspiration of pus and pulmonary atelectasis & Broncho pneumonia (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Follicular Tonsillitis & Hypertension (duration) yrs. mos. 2 7 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Luther E. Sidle, M. D.

2/12/1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hamboden — DATE OF BURIAL: Feb. 15 1930

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 3631 Falls Rd.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

FEB 13 1930

Spec.—8-16-29—L. P. S.—100 Blks.

E 54011

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54011

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Celia Derekowitz

(a) RESIDENCE NO. 31 Goodwin Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) — 637

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed FEB 13 1930, H. A. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13-30

17 I HEREBY CERTIFY, That I attended deceased from Dec 23- 1929, to 2-13, 1930, that I last saw h[illegible] alive on 2-13-1930 and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, right Cerebral, Glioma, (malignant

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Wound infection

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 26, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Clarence E Gardner Jr., M. D.

2/13 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark N. J

DATE OF BURIAL 2/13 1930

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54012

CERTIFICATE OF DEATH

31

E 54012

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Williams

(a) RESIDENCE NO. 1003 W. Saratoga st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie W. Williams

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bootblack

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Alexander Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Martha (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Hospital Records
(Address)

15 Filed B 13 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1930, to Feb. 12, 1930, that I last saw him alive on Feb. 12, 1930 and that death occurred, on the date stated above, at 1.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos. Stimmel Jr., M. D.

2-12 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Greenmount	2-15-1930
20 UNDERTAKER	ADDRESS
Jas. J. Stimmel	1625 E. Fred. st

OF DEATH in plain terms, so that it may be properly classified. Last statement of occupation most important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 100-0 E 54013

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital 4-30 ST., ... WARD)

2—FULL NAME Ella Wright

(a) RESIDENCE NO. Bentonville Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. J. Wright

6 DATE OF BIRTH (month, day, and year): July 8- 1853

7 AGE: 17 Years 7 Months 5 Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Practical Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): 048

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Phila Pa.

PARENTS

10 NAME OF FATHER: Jacob Reel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Walter J. Wright (Son)
(Address): Bentonville, Md

15 Filed ..... 1930 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1930, to Feb 13, 1930, that I last saw her alive on Feb 13, 1930, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Glenburnie, Md

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Clendaniel, M. D.

2-13-1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Cemetery Baltimore

DATE OF BURIAL: 2/16 1930

20 UNDERTAKER: Lloyd Kaiser

ADDRESS: Laurel Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

B 13 1930

Spec.--8-16-29--L. F. S.--100 Bks.

Dr Campbell ✓

E 54014 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 54014**

90

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 31 E Wheeling (ST.) 70-69 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2--FULL NAME Anna G. Stella

(a) RESIDENCE NO. 31 E Wheeling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jesse Stella

6 DATE OF BIRTH (month, day, and year): June 1, 1858

7 AGE: Years 71 | Months 8 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: John Stahle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Anna Sharp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Jesse Stella

(Address) 31 E Wheeling St

15 Filed C. HAMPSON JONES, M. D. Registrar

B 1 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1929, to Feb. 11, 1930, that I last saw h[illegible] alive on Feb. 11, 1930 and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation, Indef.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. C. H. Campbell M. D.

4/17, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 2/14 1930

20 UNDERTAKER: William Cook

ADDRESS: 1219 E Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E. 54015

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54015

CERTIFICATE OF DEATH

129

E 54015

REGISTERED NO. .....

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1476 Mc Kean Ave (Street) ..... (Ward) .....

2—FULL NAME Emma Clarke Collins

(a) RESIDENCE NO. 1476 McKean Ave. (Street) ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced. (Write the word) W.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj F Collins

6 DATE OF BIRTH (month, day, and year) Nov 3 1850

7 AGE — Years 79 Months 3 Days 8 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Wm F Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emily R Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lora Roberts

(Address) 943 McKean Ave

15 FEB 4 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11-30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2 1930, to Feb. 11 1930.

that I last saw h.W. alive on Feb. 10 1930

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis interstitial

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Chronic nephritis (duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bowman Hood M. D.

1930 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft Mcpherson Co. DATE OF BURIAL 2/14 1930

UNDERTAKER John A. Moran ADDRESS 3000 E Baltimore

E B 1 4 1930

important. See instructions on back of certificates.

DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very

Spec.--2-29-28—L. P. S.—500 Blks.

E 54016 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 54016

1—PLACE OF DEATH

CITY OF BALTIMORE (No. South Baltimore General Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME J. Frederick Deuchler

(a) RESIDENCE NO. 2225 Washington Blvd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7yrs mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer) 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo Deuchler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dora Deuchler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Dora Deuchler

(Address) 2227 Wash Blvd

15 Filed FEB 14 1930 19 H. HOWARD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-12-30

17 I HEREBY CERTIFY, That I attended deceased from 1-18, 1930 to 2-12, 1930 that I last saw him alive on 2-12, 1930 and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
& Hemorrhage

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Laukaitis, M. D.

, 19 (Address) South Baltimore Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	2/14/30
20 UNDERTAKER Edward Foulke	ADDRESS 2359 Wash

Or death in plain terms, so that it may be grouped correctly and compared with other returns. Be sure to answer every question. If none, write none. If unknown, or if the question does not apply, write unknown, or the abbreviation, "Un." Do not use ditto marks. Be particularly careful to make all figures unmistakable. Punctuation is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54017

100-001

CERTIFICATE OF DEATH

E 54017

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 1410 School St. 15-21 WARD)

2—FULL NAME James Edward Sampson

(a) RESIDENCE NO. 1410 School ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12-1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	3	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) 1845 Lorman St

PARENTS

10 NAME OF FATHER Lloyd Gant.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Marguerite Sampson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Marguerite Sampson
(Address) 1410 School St.

15 Filed FEB 14 1930, 19 C. HAMPSON JONES, M. D. Registrar

B 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 10, 1930, to Feb 12, 1930, that I last saw h[illegible] alive on Feb 11, 1930 and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. N. Wright, M. D.

2/12, 1930 (Address) 120 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 2-14 1930

20 UNDERTAKER Samuel Easter

ADDRESS 916 Eager

IF DEATH in plain terms, so that it may be properly classified. State statement of OCCUPATION as very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54018

CERTIFICATE OF DEATH

1882/03

E 54018

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hosp 18-29 St., Ward)

2-FULL NAME Jacob Forman

(a) RESIDENCE NO. 1144 E Lombard St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rosa

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mattress Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 056
(c) Name of employer City

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Meyer Forman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Julia Bender

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Rosa Forman
(Address) 1144 E Lombard st

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

18 CAUSE OF DEATH was as follows:
Struck & knocked down by moving automobile
H.C.
Fract Pelvis – Ruptr Kidney (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Fract of both Legs
(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? Pratt & Central Sts

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. J. Frame, M. D.

2/12 1930 (Address) 2939 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL Feb 14 1930

20 UNDERTAKER Sol Levinson + Bro — ADDRESS 12 1 E Balto st

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 54019

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54019

CERTIFICATE OF DEATH.

90

1. PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 23-21 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME William J. Hirsch

(a) RESIDENCE NO. 132 Burkhead St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1886 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John T. Hirsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Decker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hospitals

15 Filed FEB 14 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13-30

17 I HEREBY CERTIFY, That I attended deceased from 2-11-30, 19, to 2-13-30, 19,

that I last saw him alive on 2-13-30, 19,

and that death occurred, on the date stated above, at 1:15 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Facute

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism, chronic Facute

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marion McClean, M. D.

2-13, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 2/15 1930

20 UNDERTAKER I. Fine 1111 E. Baltimore

ADDRESS 1306 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

54020 E 54020

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Church Home & Infirmary Ward) 6-9

2-FULL NAME Grover C. Slade

(a) RESIDENCE NO. The Rocks, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie V. Slade

6 DATE OF BIRTH (month, day, and year) July 3/1884

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	45	7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ralph Slade

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Fletcher

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Isaac Slade
(Address) Rocks Maryland

Filed FEB 14 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral-Spinal Syphillis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Serological (Wasserk man)

(Signed) [illegible] M. D.

2/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jarrettsville Md — DATE OF BURIAL 2/16/30

UNDERTAKER Harry A Witzke — ADDRESS 4101 Edmondson Av

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 54021

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2107 St. Clair Lane ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Myra A. Carlin

(a) RESIDENCE NO. 2107 St. Clair Lane ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 1 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 1. 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Joseph H. Carlin

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Jane Nelson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Joseph H. Carlin

(Address) 2107 St. Clair Lane

15 Filed ..... 19.....

THOS. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 11-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1930. to Feb. 11, 1930.

that I last saw h alive on Feb. 10. 1930

and that death occurred, on the date stated above, at 4:5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

2/11, 1930 (Address) 1663 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Feb. 14 1930
20 UNDERTAKER	ADDRESS
William J. Schaefer	1826 E Monument

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 54022

CERTIFICATE OF DEATH

E 54022

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1319 N. Monroe St., 15-22 Ward)

2-FULL NAME Hazel Weston

(a) RESIDENCE NO. 1319 N. Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Feb 25 1924

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		11	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John Weston

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Hazel Gordon

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Hazel Weston
(Address) 1319 N. Monroe

15 Filed ..... 19.. C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to Death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriology

(Signed) C. Hampson Jones, M. D.
Feb 12 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Feb 14 1930
20 UNDERTAKER Thomas E. Nelson	ADDRESS 1303 Presstman St.

Spec.—1-30—M. & T.—250 Blks.

Dr Hoag 729 Washington Blvd

E 54023

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54023

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1326 Mc Henry St. 21-29 WARD)

2-FULL NAME John Rollman

(a) RESIDENCE NO. 640 Wyatt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jennie Rollman

6 DATE OF BIRTH (month, day, and year) March 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Charles Shenton (Address) 1326 Mc Henry St

15 Filed FEB 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930, to Feb 13, 1930, that I last saw him alive on Feb 12, 1930, and that death occurred, on the date stated above, at 12:20 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 1 mos da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

2/14, 1930 (Address) 729 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL 2/15/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E54024

Dup Cert
1205 W. Fayette St
Calvert 4904

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54024

CERTIFICATE OF DEATH.

90 E 54024

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2501 W. Fayette St. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. White

(a) RESIDENCE NO. 2500 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 17, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town)
(State or country) Howard County Md

PARENTS

10 NAME OF FATHER Harrison C White

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Howard County Md

12 MAIDEN NAME OF MOTHER Ellen Hawkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Howard County Md

14 Informant Mr. Chas. F. White
(Address) 2501 W. Fayette St

15 Filed FEB 14 1930 HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1930

17

I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1929, to Feb. 12, 1930, that I last saw h.. alive on February 12, 1930, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) — yrs. — mos 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis and myocarditis (duration) 8 yrs 1 yr. 5 mos. yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Ext.

(Signed) H. C. White, M. D.

2-13-30 19 (Address) 1205 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine — DATE OF BURIAL Feb 15 1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E.S-4025

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54025

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp. 2-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Culver

(a) RESIDENCE NO. 919 Payson St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or) WIFE of~~ Margaret F.

6 DATE OF BIRTH (month, day, and year) 2/13/1867

7 AGE	Years	Months	Days	11 LESS than 1 day, hrs. or ..... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Signal Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer Penna R R

9 BIRTHPLACE (city or town) (State or country) Laurel Del.

PARENTS

10 NAME OF FATHER Daniel Culver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Laurel Del.

12 MAIDEN NAME OF MOTHER Annie Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Margaret Culver (Address) 919 N. Payson St

15 FILED FEB 14 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13 1930

17

I HEREBY CERTIFY, That I attended deceased from 2-5 , 1930 , to 2-13 , 1930.

that I last saw h~~im~~live on 2-13 , 1930

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 20 yrs mos ds.

CONTRIBUTORY (Secondary) Gangrene - (toxaemia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of 2-11-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) M D Blundon, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 2/17 1930

20 UNDERTAKER Wm. Cook — ADDRESS 1217 E Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54026

CERTIFICATE OF DEATH.

117 E 54026

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) Edmondson & Aisquith Sts. (WARD) 46

2-FULL NAME Cecilia M. Knies

(a) RESIDENCE NO. 1724 Garrison Ave STR. WARD 32

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 2 mos. 21 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): November 21 1906

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
23	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Conrad Knies

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Ina Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mr. Conrad Knies

(Address) 1724 Colonial Ave.

15 Filed FEB 14 1930

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): FEB 12 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-31-30, 19 to 2-12-30, 19,

that I last saw h alive on 2-12-30, 19, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2-1-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) M. Hunter, M. D.

2/14 1930 Address St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Feb. 15 1930

20 UNDERTAKER: Henry Hoeck Sons Inc. — ADDRESS: 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54027

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54027

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 26-41

CITY OF BALTIMORE: (No.) 4138 Eierman Ave ST. — WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosina Albrecht

(a) RESIDENCE NO. 4138 Eierman Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Wm. C. Albrecht

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years: about 84 | Months: — | Days: — | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. Vernon Evans

(Address) 4138 Eierman Ave.

15 Filed ..., 19... Registrar

E HAMPSON JONES, M.

FEB 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): FEB 13 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Feb 13, 1930, that I last saw h[illegible] alive on Feb 12, 1930 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fuchs, M. D.

2/14 1930 (Address) 1823 N. Wash St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb. 17 1930
20 UNDERTAKER	ADDRESS
Henry Hauck Sons, Inc.	1201 E. Eager St

important. See instructions on back of certificates.

Spec.—2-29-28—1. F. S.—500 Bks.

Olive Hughes.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001

E 54028

CERTIFICATE OF DEATH

E 54028

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Eutaw Place ST. 24 35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Olive Hughes

(a) RESIDENCE NO. 1227 Lanvale St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. / mos. / ds. How long in U. S., if foreign birth? / yrs. / mos. / ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Hughes

6 DATE OF BIRTH (month, day, and year) Nov 26 1904

7 AGE 25 Years	Months 2	Days 16	If LESS than 1 day, ... hrs. or ... min.
	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William Henry

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Emma Wagner

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Hospital records. (Address)

15 Filed ..., 19 ... Registrar

B 141930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/11/30

17 I HEREBY CERTIFY, That I attended deceased from 1/26/30, 19..., to 2/12/30, 19..., that I last saw her alive on 2/10/30, 19..., and that death occurred, on the date stated above, at 1:40 A m.

The CAUSE OF DEATH* was as follows:

Epidermoid carcinoma of cervix

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute nephritis-anuria

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 2/4/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

2/11/30 (Signed) Jno. A. Sampson, M. D.

(Address) John Hopkins Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Feb 13 1930
20 UNDERTAKER Chas. L. Ellis	ADDRESS 1537 E Fay

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

132363 E 54029 90 ✓ E 54029

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2—FULL NAME Victor Power

(a) RESIDENCE NO. Washington apts ST., Mt Vernon Place & Chas St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Woolford

6 DATE OF BIRTH (month, day, and year) Jan-23-69

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
61	60	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work News Publishers

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Manfrs Record Balto Co.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katharine Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 14 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Mar. —, 1925, to Feb. 12, 1930, that I last saw h[illegible] alive on Feb 12, 1930 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Coronary Embolism

— (duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) Chronic myocarditis arteriosclerosis (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas H Gay, M. D.

19 (Address) 1014 St. Paul St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 2/15 1930

20 UNDERTAKER Henry W. Meeks and Son

ADDRESS 805 W. Calvert

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54030

CERTIFICATE OF DEATH

90 ✓

E 54030
REGISTERED NO.

21-24

1-PLACE OF DEATH

City of Baltimore: (No. 640 Wyeth St St.) (21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Rollman

(a) RESIDENCE NO. 640 Wyeth St St., Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Rollman

6 DATE OF BIRTH (month, day, and year) July 9 1865

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
64	7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Levin Pearson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Chas L Henton
(Address) 1326 Mc Henry St

Filed FEB 14 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13 1930

17 I HEREBY CERTIFY, That I took charge of the remains desccibed above, held an Inquiry (Inquest, autopsy or inquiry.) theccon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas L Brooke M. D.

2/14 1930 (Address) Brooklyn Md

*State the Disease Causing Death, oc in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 2/15 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Pratt

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly. Cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 54031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 54031

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Provident Hospital WARD)

2—FULL NAME Sara Knight

(a) RESIDENCE NO. 733 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Knight

6 DATE OF BIRTH (month, day, and year) Nov 14 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER George Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lovenia Satchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Katherine Stokes

(Address) 810 Mulberry St.

15 Filed ... 19 ... Registrar

FEB 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-10-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to Feb 10, 1930

that I last saw h alive on Feb 10, 1930

and that death occurred, on the date stated above, at 6 30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) about yrs. 3½ mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Carroll M. St Clair, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb. 14, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54032

CERTIFICATE OF DEATH.

114 E 54032

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland St. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Elkin

(a) RESIDENCE NO. 2544 Pamega Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~Life~~ 2 yrs 4 mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7th 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
15	15 yrs.	3 mos.	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or estsblishment in which employed (or employer) 000

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Newark N. J.

PARENTS

10 NAME OF FATHER Joseph Elkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Slatin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14. Informant Joseph Elkin (Address) 2544 Pamega Ave

15 Filed FEB 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1930, to Feb. 13, 1930,

that I last saw her alive on Feb. 13, 1930,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pelvic Inflam. Dis. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/13/30 Incision + Drainage

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Friedman, M. D.

19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rond[illegible] DATE OF BURIAL 2/[illegible]/30

20 UNDERTAKER Jack Levis ADDRESS 1409 E[illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54033

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185

E 54033

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 15-21 Ward)

2-FULL NAME Mollie Herman

(a) RESIDENCE NO. 1705 N. Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Louis Herman

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
about 68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Yana

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Dobia

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto., Md.

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia.
Fractured rt femur at hip.
Accidentl fell over rug in her home Feb 8/30 (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Bloom, M. D.

2/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rest 2/14 1930

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S entry OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 54034

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Pronounced dead from Ch. Myocarditis 18 Westfield St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mollie Newman Nelson

(a) RESIDENCE NO. 148 Bowers Court St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	61			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie Boston

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Ida Thompson
(Address) 1032 W. Lexington

Filed FEB 14 1930 19 C. HAMPSON JONES, M. D.
Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Chas. H. Brooks M. D.
Feb. 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Albion	2/15 1930
20 UNDERTAKER Daniel Coates	ADDRESS 916 Pine

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54035
1PLACE OF DEATH

CERTIFICATE OF DEATH.

90 E 54035
REGISTERED No. C

CITY OF BALTIMORE (No. 1701 W. North Ave St. 15-21 WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Langmann

(Residence in Baltimore: No. 1701 W. North ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): married

6-DATE OF BIRTH, Oct. (Month) 2 (Day), 1868 (Year)

7-AGE, 61 yrs. 5 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Grocer
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, William Langmann

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Elizabeth Arnold

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Langmann

(Address) 1701 W. North Ave

15- Filed FEB 14 1930 HARRISON JONES, M. D. Registrar.
Per

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 13 (Day), 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Sudden

(Duration) yrs.

CONTRIBUTORY (Secondary)

(Duration) yrs. 0 mos. 2 ds.

(Signed) H. Carl Leuck M. D. (Coroner.)

Feb 13, 1930 (Address) North Ave & Bonn

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park

DATE OF BURIAL, Feb. 17, 1930

20-UNDERTAKER: Josiah Lyser

ADDRESS 1600 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54036

CERTIFICATE OF DEATH

90 ✓ Dr Heller

REGISTERED NO. E 54036

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 S. Duncan ST., V-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Appel

(a) RESIDENCE NO. 314 S. Duncan ST., 1 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Charles E. Appel

6 DATE OF BIRTH (month, day, and year) Jan 22 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Miller

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Dressel

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Charles H. Appel
(Address) 314 S. Duncan St.

15 Filed FEB 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 11th 30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2 - 1930, to Feb 11, 1930, that I last saw her alive on Feb 11 1930, and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

Grippe (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Geo Kelley M. D.

(Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem.

DATE OF BURIAL Feb. 14 1930

20 UNDERTAKER Lilly & Geiler Inc.

ADDRESS 403 S. Wolfe St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 ✓ E 54037

E 54037

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S Exeter ST. 325 WARD)

2—FULL NAME Bambina Foglia

(a) RESIDENCE NO. 414 S Exeter ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Michael Foglia ?

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... Hrs. or ... min.
	70 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER ? Foglia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Loretta Trini

(Address) 414 S Exeter St

15 Filed FEB 14 1930, 19 C. HAMPSON JONES, M. D. Registrar

E B 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-13-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1928, to Feb 12, 1930, (that I last saw h.. alive on Feb 12, 1930) and that death occurred, on the date stated above, at 8 50 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jos L. Valentuolo M. D.

(Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Feb 17, 1930

20 UNDERTAKER M. W. E. Dippel

ADDRESS 37 Lam

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 E 54038

REGISTERED NO.

1—PLACE OF DEATH Hospital for Women of Md. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore, Md. ST. 17-50 WARD)

2—FULL NAME Mrs. Ida Mae Waters

(a) RESIDENCE NO. 2643 N. Charles ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U. S., If foreign birth? life mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willard G. Waters

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Patterson, N.J.

PARENTS

10 NAME OF FATHER William Fielding

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Eliza J. Heflin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York New York

14 Informant Willard G. Waters

(Address) 2643 N. Charles St.

15 Filed FEB 14 1930 H. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1930, to Feb. 12, 1930, that I last saw h[illegible] alive on Feb. 12, 1930, and that death occurred, on the date stated above, at 7.35 p. m.

The CAUSE OF DEATH* was as follows:

Cystic glioma right temporal lobe

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Carl P. Clemson, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Patterson N.J. DATE OF BURIAL Feb 15 1930

20 UNDERTAKER Peter O. Hatchell Funeral Home ADDRESS 1900 Eutaw Place

FEB 14 1930

important. See instructions on back of certificates.

Spec. 7-17-26 A Cap 200 Bks.

E 54039

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 54039

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Aged Mens Home.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 1400 W Lexington St. 14-27 Ward)

2-FULL NAME Benjamin Hawkins

(a) RESIDENCE NO 1400 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Fifty yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24, 1853

7 AGE: Years 76 Months 1 Days 20. IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER James Hawkins

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Knight

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant Mrs Mary Forester

(Address) 1400 W Lexington

Filed FEB 14 1930 C. HAMPSON JONES, M. D. Registrar

By RCP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15 1927 to Feb 14, 1930

that I last saw him alive on Feb 6, 1930

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin O Jarrett M. D.

, 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Etc. Western Cemetery

Date of Burial Feb 15 1930

20 UNDERTAKER George J Smith

ADDRESS 153 L Hollins

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B 14 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Masses 101-001

54040 X 101-001 E 54040

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Union Memorial Hospital ST 12-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2—FULL NAME William Page

(a) RESIDENCE NO. 6 Lyndon, P.O. Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	not known about 45 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chicken Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. V. W. Elder

9 BIRTHPLACE (city or town) England
(State or country)

PARENTS

10 NAME OF FATHER not Known

11 BIRTHPLACE OF FATHER (city or town) not Known
(State or country)

12 MAIDEN NAME OF MOTHER not Known

13 BIRTHPLACE OF MOTHER (city or town) not Known
(State or country)

14 Informant Mr. V. W. Elder
(Address) Reisterstown Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 7, 1930, to February 9, 1930, that I last saw h. alive on February 9, 1930 and that death occurred, on the date stated above, at 2 05 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 22 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Reinhold T. Shackelford, M. D.

Feb 9, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL Feb 14 1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

important. See instructions on back of certificates.

B 1 1930 H. M. [illegible]

Spec—1-30—M. & T.—300 Blks.

Dr F C Smith 2516 Pennsylvania Ave

E 54041 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54041

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3420 Mondawmin Ave (Ward) 15-1a1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Jackson Cooke

(a) RESIDENCE No. 3420 Mondawmin Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Emma V. Cook

6 DATE OF BIRTH (month, day, and year) 3/19/1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	62	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stair Builder

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer Cook & Reese

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER George Lewis Cooke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Emma V. Cooke

(Address) 3420 Mondawmin ave

15 Registered FEB 14 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Feb 13, 1930, that I last saw him alive on Feb 13, 1930, and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

Contributory Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/21/29

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) Fred C Smith, M. D.

Feb 14, 1930 (Address) 2516 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 2/15/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54042

E 54042

CERTIFICATE OF DEATH.

REGISTERED NO. 23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3609 Liberty Heights Ave (St.) 15-61 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Washington Honsberger

(a) RESIDENCE No. 3609 Liberty Heights Ave. (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude M Honsberger

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commercial Agent 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer W. U. Telegraph Co.

9 BIRTHPLACE (city or town) (State or country) W. Brownsville Pa.

PARENTS

10 NAME OF FATHER Jacob Honsberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Z.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs. Gertrude M. Honsberger (Address) 3609 Liberty Heights Ave

15 Filed FEB 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from 12/1 1929, to 2/11 1930,

that I last saw h[illegible] alive on 2/11 1930,

and that death occurred, on the date stated above, at 6.07 P.M.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. 2 mos 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys + Laboratory

(Signed) C Hampson Jones, M. D.

2/13, 1930 (Address) 817 Fort Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Feb. 14 1930

20 UNDERTAKER Wm Tickner & Sons ADDRESS North & Pa

CAUSE OF DEATH. See instructions on back of certificates. CERTIFICATION is very important

B

Spec.—1-10-21—M&T—1500 Blks.

E 54043

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54043

CERTIFICATE OF DEATH

1-PLACE OF DEATH 1706 Monterey Ave

CITY OF BALTIMORE: (NO.) ST. 05-72 WARD 2

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna L. Goodrich

(a) RESIDENCE NO. 1706 Monterey Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Geo. A. Goodrich

6 DATE OF BIRTH (month, day, and year) Sept 4th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Louis Dahl

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eva Wagner

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany

14 Informant: Mrs R. L. Eddy (Address) 1706 Monterey Ave

15 Filed FEB 14 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from August 6, 1929 to Feb. 12, 1930 that I last saw her alive on Feb. 12, 1930 and that death occurred, on the date stated above, at 7.10 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1708 Monterey Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm. Asthanos M. D.

2/12, 1930 (Address) 1901 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL 2/15/1930

20 UNDERTAKER: John J. Cowan & Son — ADDRESS 901 Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 54044

E 54044

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. W. Balto Gen Hosp St. 14-27 Ward)

2-FULL NAME Mamie Downes

(a) RESIDENCE NO. 1571 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	Col'd	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) Dec 29-1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	32	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Sadie Thomas
(Address) 1571 W. Saratoga

15 Filed FEB 14 1930 C. HAMILTON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Bruch, M. D.

Feb 12 1930 (Address) Courier

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL Feb 15 1930

20 UNDERTAKER Joseph A Lively — ADDRESS 409 N. Mount St

B 14 1930

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001

E 54045

CERTIFICATE OF DEATH

E 54045

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 Barclay ST. 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Fagan

(a) RESIDENCE NO. 2410 Barclay ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	M.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella A Fagan

6 DATE OF BIRTH (month, day, and year) Dec 17 69

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boilermaker 080

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Fagan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rehm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ella A Fagan

(Address) 2410 Barclay St

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

E 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13. 30.

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Feb 13, 1930, that I last saw him alive on Feb 12, 1930, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Exopthalmic Goiter

..... (duration) Unknown.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) Unknown

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Dec - 1929

Was there an autopsy? No

What test confirmed diagnosis? P.C.

(Signed) Chas. R. Greenstone M. D.

19 (Address) 7923 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park Bur

DATE OF BURIAL Feb 15 1930

20 UNDERTAKER W M Routson

ADDRESS 2238 N Mtb

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Bray

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓ E 54046

E 54046

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 S Cary ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Bray

(a) RESIDENCE NO. 115 S Cary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Bray

6 DATE OF BIRTH (month, day, and year) 1877 Jan 30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Bray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Whelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Catherine Bray

(Address) 115 S Cary St

15 Filed FEB 14 1930, 19 C. HAMPSON JONES, M. D. Registrar

B 14 1030

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14/30

17 I HEREBY CERTIFY, That I attended deceased from 2/1/30, 19, to 2/14/30, 19,

that I last saw h alive on 2/13/30, 19

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pul. Phthisis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? P.E. Hist. Sanatoria Sc

(Signed) Bernard Fenny, M. D.

2/14/1930 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Feb 17 1930

20 UNDERTAKER John J Fildo

ADDRESS 1200 W Lombard

Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54047

CERTIFICATE OF DEATH.

E 54047

REGISTERED NO. 91-002 E 54047

1-PLACE OF DEATH Balto. Cty Eye Ear & Throat Hosp.

CITY OF BALTIMORE: (NO. 1214 Eutaw Place ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Monaghan

(a) RESIDENCE. NO. 626 St. Ann Ave ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Monaghan

6 DATE OF BIRTH (month, day, and year) 12-23-1892

7 AGE Years	Months	Days 19	If LESS than 1 day, hrs. or min.
37	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto-mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Mon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kathrine Grace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs T Monaghan
(Address) 626 St Ann Ave

15 Filed ..... 19 ..... Registrar

FEB 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1930, to Feb. 12, 1930, that I last saw h. alive on Feb. 12, 1930, and that death occurred, on the date stated above, at 8.53 a.m.

The CAUSE OF DEATH* was as follows:

Streptococcic meningitis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Endocarditis. 91-2

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At hospital

Did an operation precede death? Yes Date of Feb. 6, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Spinal fluid; lab.

(Signed) M McLawens, M. D.

19 (Address) Balto. Cty Ea & Throat Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Feb 15 1930

20 UNDERTAKER Mary M. Wudefield

ADDRESS 201 E. 22nd St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54048

CERTIFICATE OF DEATH

129 ✓ E 54048

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5332 Maple ave. ST 27-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Ryan

(a) RESIDENCE NO. 5332 Maple Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

a ~~Married~~, widowed, ~~or divorced~~
~~HUSBAND~~ of
(or) WIFE of Henry Clay Ryan

6 DATE OF BIRTH (month, day, and year) Apr. 3- 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Wm Cadogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mathias Remesch

(Address) 5332 Maple Ave. B

15 Filed FEB 14 1930 C. HAMPSON [illegible] Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 12-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Feb. 12, 1930, that I last saw h alive on Feb 12, 1930 and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) Paul Brown, M. D.

2/12/1930 (Address) 1663 20 North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cems

DATE OF BURIAL 2/15/30

20 UNDERTAKER Vernon Lemmon

ADDRESS 4513 Park Heights

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Charles B Rose. ✓

E 54049

HEALTH DEPARTMENT—CITY OF BALTIMORE

101 101 E 54049

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital
CITY OF BALTIMORE: (No. Catox & Wilkes Aves S. 19-28 WARD)

2-FULL NAME Charles Rose

(a) RESIDENCE NO. 1630 Mc Henry ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia Rose

6 DATE OF BIRTH (month, day, and year): April 22 1861

7 AGE: 68 Years 9 Months 20 Days — If LESS than 1 day, hrs. or .... min.
69

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS
10 NAME OF FATHER: Max Vonorlensen
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Rebea Rose
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Daisy Rose (Address): 1630 McHenry St

15 Filed FEB 14 1930 19.. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-12 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-11 , 1930 , to 2-12 , 1930 ,
that I last saw him alive on 2-12 , 1930 ,
and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows: a Lobar pneumonia, both bases

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) George Brenner, M. D.
2/12, 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem
DATE OF BURIAL: 2/15 1930

20 UNDERTAKER: Robert Brooks & Son
ADDRESS: Calhoun Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 54050 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54050

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Aves ST. 25-72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Ehatt

(a) RESIDENCE NO. Linden Ave-East Drive ST. Arbutus WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? 30 ans yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Ehatt

6 DATE OF BIRTH (month, day, and year) Jan 21st 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Leonard Kessel

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaret Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Martin Ehatt

(Address) Linden Ave & E Drive

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1930, to Feb 12, 1930, that I last saw her alive on Feb 12, 1930, and that death occurred, on the date stated above, at 4.50 A m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Generalized peritonitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of Feb 10

Was there an autopsy?

What test confirmed diagnosis? none (clinical)

(Signed) Ernest Spencer Jr. M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 2/15/1930

20 UNDERTAKER F. S. Wippert — ADDRESS 850 N. Bond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 14 1930 HAMILTON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54051
REGISTERED NO.

E 54051
1-PLACE OF DEATH

City of Baltimore: (No. 1911 W Balto St. 20-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Orrin Gilpin

(a) RESIDENCE NO. 1911 W. Baltimore St., 173 W. 54th St. Ward New York City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rosa G. Gilpin

6 DATE OF BIRTH (month, day, and year) April 18-1899

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	30	9	25 26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Edward L. Gilpin

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Jones

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. S. Gilpin
(Address) 911 W Baltimore St

15 Filed FEB 14 1930, 19 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to L death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
following Grippe

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Boorsley M. D.

Feb 13, 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Feb 15th 1930
20 UNDERTAKER	ADDRESS
F. D. Wiglust	155 N. Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54052

CERTIFICATE OF DEATH

90 E 54052

1—PLACE OF DEATH (Mercy Hospital)

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 20-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr Henry Sinsheimer

(a) RESIDENCE NO. 1918 W. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 5 mos. 4 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Sinsheimer

6 DATE OF BIRTH (month, day, and year) Sept 10 - 186

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
69	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) =

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Sinsheimer

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER ~~Hammel~~ Fannie Hertzog

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Hospital Records Mary Sinsheimer
(Address) 1918 W. Fayette St

15 Filed FEB 14 1930 WM. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 18, 1929, to Feb 14, 1930, that I last saw h[illegible] alive on Feb 14, 1930 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic cardiovascular disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Heyle, M. D.

2-14 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Feb 17th 1930
20 UNDERTAKER	ADDRESS
H B Shipley	1850 W Balto St

IMPORTANT. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Bks.

E 54053

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-09

E 54053

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Linden ave St., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abrilla Hatton Brashear

(a) RESIDENCE NO. 1714 Linden ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8V yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8V	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Francis Nathaniel Brashear

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Rebecca Hatton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs William F. Cable

(Address) 4220 Norwood Road

15 Filed FEB 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6th 1930 to Feb. 14th 1930, that I last saw her alive on Feb. 10th 1930 and that death occurred, on the date stated above, at 11-V1 P m.

The CAUSE OF DEATH* was as follows:

Double Bronchitis.

8 or 10 days duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ? (duration) yrs. mos. D. C.

18 Where was disease contracted if not at place of death? Probably Washington

Did an operation precede death? X Date of X

Was there an autopsy? X

What test confirmed diagnosis?

(Signed) Edward L. Boyd, M. D.

19 (Address) 1765 Parkwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Park Cemetery

DATE OF BURIAL Feb 15 1930

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. North ave

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54054

E 54054

Ped.

CERTIFICATE OF DEATH

24

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maude Rees

(a) RESIDENCE NO. 19 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	—

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/8/24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Isaac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13-30

17 I HEREBY CERTIFY, That I attended deceased from 2-12-30, 19..., to 2-13-, 19 30, that I last saw h alive on 2-13, 19 30 and that death occurred, on the date stated above, at 1556 m.

The CAUSE OF DEATH* was as follows:

Meningococcus sepsis c C. N. S. involvement. (meningitis)

(duration) ...yrs. ...mos. 1 ds.

CONTRIBUTORY (Secondary) none

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. R. Buckford, M. D.

2/14, 1930 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL FEB 14 1930

20 UNDERTAKER Undertaker Posite

ADDRESS

1—important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23E 54055 — E 54055 — 31

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herman Peterson

(a) RESIDENCE NO. 1837 Jefferson ST., St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly

(b) General nature of industry, business, or establishment in which employed (or employer) Hosp

(c) Name of employer

9 BIRTHPLACE (city or town) Pa.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Peterson

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Julia Butler

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 14 1930 19 C. HAMPSON JONES, M. D. Registrar
1361

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 2 30

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to Feb 2, 1930, that I last saw h[illegible] alive on Feb 2, 1930 and that death occurred, on the date stated above, at 8 25 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path Examination

(Signed) Alexander Punton, M. D.

19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: FEB 14 1930 19

20 UNDERTAKER: Commissioner Health

ADDRESS

IMPORTANT. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 54656

HEALTH DEPARTMENT—CITY OF BALTIMORE

107 E 54056

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST 18-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emanuel Johnson

(a) RESIDENCE NO. 1135 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 24 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Car.

PARENTS

10 NAME OF FATHER Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Car

12 MAIDEN NAME OF MOTHER Lraima McClean

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Nar

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 4 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-9-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to Feb 9, 1930,

that I last saw him alive on Feb 9, 1930

and that death occurred, on the date stated above, at 2 10A m.

The CAUSE OF DEATH* was as follows:

Pulmonary abscess

6 mths

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sm Exam

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: FEB 14 1930

20 UNDERTAKER: Commissioner Health

ADDRESS

C. HAMPSON JONES, M. D.

4363

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54057

CERTIFICATE OF DEATH

118-002 E 54057

1—PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1800 St. Paul ST. 17-19 WARD)

2—FULL NAME Helen Lamping

(a) RESIDENCE NO. 1800 St. Paul ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced (or) WIFE of Clemens Lamping

6 DATE OF BIRTH (month, day, and year) Feb. 8, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	82		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (City or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Starr

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Guildener

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Frances Lamping (Address) 1800 St. Paul Street

15 Filed FEB 14 1930, 19__ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13/30

17 I HEREBY CERTIFY that I attended deceased from Jan 14, 19__, to Feb 13, 19__, that I last saw h__ alive on Feb 13/30, 19__ and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) ___ yrs. 1 mos. ___ ds.

CONTRIBUTORY (Secondary) Toxemia (duration) ___ yrs. ___ mos. 10 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Walter D. Wyse, M. D.

19__ (Address) 1150 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

20 UNDERTAKER Chas J. Jenkins Sons Co

DATE OF BURIAL 2-16 1930

ADDRESS Orchard & Eutaw Sts

B 14 1930

OF DEATH in plain terms, as much as important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54058

E 54058

CERTIFICATE OF DEATH

38

1—PLACE OF DEATH Baltimore City Hospitals (Tbc ST. 18-110 WARD) REGISTERED NO.

CITY OF BALTIMORE: (No.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Riley

(a) RESIDENCE NO. 926 W. Fayette st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 31

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Alex. Riley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Louise French

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Hospital Records
(Address)

FEB 14 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1928, to Feb. 13, 1930, that I last saw him alive on Feb. 13, 1930 and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis over

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas Arnold Jr., M. D.

2-13-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Feb 15 1930
20 UNDERTAKER Ebenezer Ellison	ADDRESS 3417 Eastern Ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 51059

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51059

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto City Hosp. (ST.) 7-12 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Blanche Reali

(a) RESIDENCE NO. 2432 Ashland Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Reali

6 DATE OF BIRTH (month, day, and year) [redacted] 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40	41	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Pappino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Hospital Record

15 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 12-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1929 to Feb. 12, 1930

that I last saw her alive on Feb 12, 1930

and that death occurred, on the date stated above, at 12:30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Insufficient (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Jas Glennon Jr. M. D.

. 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 15 1930
20 UNDERTAKER	ADDRESS
Wendell J Leppold	300 S Eden

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54060

CERTIFICATE OF DEATH

24001 ✓ 54060

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 S Longon ST., 20-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lewis L. Shifley

(a) RESIDENCE NO. 232 S Londonave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T. Shifley

6 DATE OF BIRTH (month, day, and year) Dec 18 1863

7 AGE Years 66 Months 1 Days 29 If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Tube Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10 NAME OF FATHER Benj. O. Shifley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Margaret Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant Mary T. Shifley

(Address) 232 S. London Ave

15 Filed FEB 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/12/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to Feb 12, 1930, that I last saw him alive on Feb 12, 1930 and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Henry C. Ohls M. D.

(Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Feb. 15, 1930

20 UNDERTAKER John A. Treacy

ADDRESS 3000 E. Balto

important. See instructions on back of certificates.

B 14 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54061

CERTIFICATE OF DEATH

X 146 E 54061

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Thersa J. Koelbel

(a) RESIDENCE NO. Myrtle St., Essex, Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Simon Koelbel

6 DATE OF BIRTH (month, day, and year) June 24/1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Chesholovia, Bohemia

PARENTS

10 NAME OF FATHER James Vitak

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Simon Koelbel
(Address) Myrtle St., Essex, Md

15 Filed ..... 19.... Registrar

B 14 1930 C. HAMPSON JONES M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerpal Septicemia
Partuition Feb 7/30

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. R. Boles, M. D.

2/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cem — DATE OF BURIAL Feb 16 19..

20 UNDERTAKER August Tasch — ADDRESS 2406 Orkland Ave

tion should be carefully supplied. AGE should be stated EXACTLY. Prevention of OF DEATH in plain terms, so that it may be properly classified. Exact statement of important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 54062

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54062

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2234 (St.) Madison Ave (Ward) 14-20

2-FULL NAME George H. Buchanan

(a) RESIDENCE NO. 2234 Madison Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... da. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Nettie Buchanan

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
66	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Buchanan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Nettie Buchanan 2234 Madison

15 FILED ..... 19 .....
DEC 14 1930 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 29th 1930 to Feb 13th 1930, that I last saw him alive on Feb 13th 1930, and that death occurred, on the date stated above, at 7 00 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Geo. H. Lauenbach M. D.

2-14 1930 (Address) 225 N. Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 2/15/1930

UNDERTAKER Mrs. George E. Collard

ADDRESS 1611 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54063

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54063

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2031 Division ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nannie Grant

(a) RESIDENCE NO. 2031 Division ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm.

6 DATE OF BIRTH (month, day, and year) ? 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Nannie Dunmore

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant William Grant
(Address) 2031 Division St

15 Filed 1 4 1930 C. HAMPSON JONES, M. D.
Registrar
By ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930, to Feb 13, 1930, that I last saw h[illegible] alive on Feb 13, 1930 and that death occurred, on the date stated above, at 12 1/2 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) J. S. McCard, M. D.

2/14, 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 2/16/1930

20 UNDERTAKER Jos. Holland

ADDRESS 1631 Druid Hill

important. See instructions on back of certificates.

E 54064

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54064

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals S. 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Rebecca Snow (St.; 76 yrs., 11 mos., 2 ds.)

(Residence in Baltimore: No. 1210 Bolton Street.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Single

6-DATE OF BIRTH. March (Month) 11 (Day) 1852 (Year)

7-AGE. 76 yrs. 11 mos. 2 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Wm F. Snow

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Anna C. Conradt

13-BIRTHPLACE OF MOTHER, (State or Country). Frederick, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Frederick C. Snow

(Address) 1210 Bolton Street.

15- Filed ..... 192.... C. HAMPTON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. (Month) 13 (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ... yrs. ... mos. 1 ds.

(Signed) G. E. Lattes, M. D. (Coroner.)

..., 19... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). In the State ... yrs. ... mos. ... ds. At place of death ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Loudon Park Cemetery Feb 15 19 30

20-UNDERTAKER. Wm J Tickner & Sons ADDRESS 1 La Ave

state CAUSE OF DEATH in plain terms, so that it may be understood; is very important. See instructions on back of certificate.

FEB 15 1930

Spec.—1-30—M. & T.—250 Bks.

E 54065 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 54065

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3307 Elgin Ave ST. 15-61 WARD)

2-FULL NAME Estelle See Nunnsen

(a) RESIDENCE NO. 3307 Elgin Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George E. Nunnsen

6 DATE OF BIRTH (month, day, and year) May 5th-1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
62	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Sweden's Weight
(State or country) Baltimore Co., Md.

PARENTS

10 NAME OF FATHER Samuelle Miller

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore Co., Md.

12 MAIDEN NAME OF MOTHER Sarah Scarlett

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto. Co. Md.

14 Informant Jessie Summers Niece
(Address) 3307 Elgin Ave

15 Filed FEB 15 1930, 19..... Registrar C. HAMPSON JONES, M. D.

B 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13th

17 I HEREBY CERTIFY, That I attended deceased from Feby 8- 1930, to Feby-13 1930, that last saw h[illegible] alive on Feb 13 1930, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 5 ds.

CONTRIBUTORY —
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no.

What test confirmed diagnosis Clinical & Laboratory

(Signed) J. Wesley Cole, M. D.

2/14 1930 (Address) 2204 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Feb. 15 1930

20 UNDERTAKER Wm. J. McCurdy Sons — ADDRESS North & Penna Ave.

TION is very important See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54066

E 54066

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rena Carter

(a) RESIDENCE NO. 1916 E. Eager ST. St —WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/8/29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2 1/2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19... C. HAMPSON JONES, M. D.
(Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-3-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930, to Feb -, 1930, that I last saw her alive on Feb 3, 1930 and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Unknown

Child died at time of coming to dispensary (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Rothschild MD, M. D.

19 30 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

FEB 12 1930

Commissioner Health

Important. See instructions on back of certificates.

B 15 1930 58

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54067 90 E 54067

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 Edgewood ST. 16-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes C. Buckley

(a) RESIDENCE NO. 604 Edgewood ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 3 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3	17 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER John J Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Va.

14 Informant Mrs Agnes C Buckley

(Address) 2233 Fulton Ave.

15 Filed 1 5 1930, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 13th 1930.

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1929, to Feb 13, 1930, that I last saw her alive on Feb 13, 1930 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) L. A. Lally, M. D.

, 19 (Address) 3517 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	2/17/1930
UNDERTAKER John J Cowan & Son.	ADDRESS 901 Gilmor St.

Important. See instructions on back of certificates.

B

Spec.—8-16-29—L. F. S.—100 Bks.

E 54068 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 54068

CERTIFICATE OF DEATH

REGISTERED NO. 7-12

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 820 N. Castle ST. WARD)

2—FULL NAME Elizabeth Kley

(a) RESIDENCE NO. 820 N. Castle ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustave Kley

6 DATE OF BIRTH (month, day, and year) July 10, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	10 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Togle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gustave Kley (Address) 820 N. Castle St.

15 Filed C. HAMPSON JONES, M. D. Registrar

FEB 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 9, 1930, to Feb 13, 1930, that I last saw h[illegible] alive on Feb 13, 1930 and that death occurred, on the date stated above, at 11:55 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Carl C Rosling, M. D.

19 (Address) 1822 W. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Feb. 17 1930

20 UNDERTAKER Wm. C. Miller & Son

ADDRESS 2334 Jefferson St.

B

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54069

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 ✓ E 54069

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH: Pronounced dead at

City of Baltimore: (No. Hopkins Hospital St 2637 Ward)

2-FULL NAME: John Bach

(a) RESIDENCE NO. 125 S. 11th St St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11/1918

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	11	7	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Bach

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Rose Becke

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto., Md.

14 Informant Rose Bach (Mother)
(Address) 125 S. 11 th St

15 Filed FEB 15 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Drowned- fell thru ice while playing on pond Monument & Highland Ave. Accidental

(duration) ..yrs. ..mos. ..da.

CONTRIBUTORY (Secondary) .....
(duration) ..yrs. ..mos. ..da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. H. Watkins, M. D.

2/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fuhr Memorial Evergreen Cem

DATE OF BURIAL Feb 15 30

20 UNDERTAKER Mrs L. Miller Sons

ADDRESS Jefferson St

tion should be carefully supplied. AGE should be stated in years. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

St Thomas Washington Blvd & Giffin's Sta

E 54070 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54070

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 Sexton St 25-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna S. Kendler

(a) RESIDENCE NO. 1807 Sexton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Lawrence Kendler

6 DATE OF BIRTH (month, day, and year) Oct 9-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 37

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lawrence Kendler (Address) 1807 Sexton st

Filed Feb 15 1930. 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14/1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 1930, to Feb. 14, 1930, that I last saw her alive on Feb. 14, 1930, and that death occurred, on the date stated above, at 4.30 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(duration) 7 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm A Evans, M. D.

2/17, 1930 (Address) 1901 Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 2/17/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

TION is very important See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54071

E 54071

CERTIFICATE OF DEATH.

135

REGISTERED NO. 70-64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. West Balto. Gen'l Hosp ST. ..... WARD .....)

2-FULL NAME Frank D Carlton

(a) RESIDENCE NO. 2233 Christian ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~
HUSBAND of ~~(or) WIFE of~~ Eva Carlton

6 DATE OF BIRTH (month, day, and year) 9/10/1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sophia Major

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Eva Carlton
(Address) 214 Frederick Rd

15 Filed ..... , 19 C. HAMPSON JONES, M. D. Registrar

B 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1930, to Feb. 14, 1930, that I last saw h~~im~~ alive on Feb. 14, 1930 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Uremia (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 2/7/30

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) S. D. Flexner, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/17/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul st

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54072

CERTIFICATE OF DEATH

90 ✓ E 54072

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1108 N Entow Alley St., 11-24 Ward)

2-FULL NAME Charles H Blue

(a) RESIDENCE NO. 1108 N Entow Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	About 60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fruit Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown dec
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Marie J Courtney
(Address) 610 Lennox St

15 ..... 19.....

C. HAMPSON ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Feb 14/30 Edward Schwartz, M. D.

(Address) 1 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 2/15 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Fayette St

1 3 1930

Filed ..... 19.....

Registrar

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks. Dr Calvin House 1901 Eutaw Place

E 54073 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54073

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3336 Old Fredk St. 20-10 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Dolch

(a) RESIDENCE NO. 3336 Old Fredk Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If ~~married, widowed~~, or divorced
HUSBAND of
(or) ~~WIFE of~~ Mary

6 DATE OF BIRTH (month, day, and year) 5/30/1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer old
(b) General nature of industry, business, or establishment in which employed (or employer) Butcher
(c) Name of employer Balto Butchers Abattoir Co

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John W Dolch

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Maynie Dolch
(Address) 302 S Franklintown Rd

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M.
FEB 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/30

17 I HEREBY CERTIFY, ~~That I attended deceased from~~
Jan 9th, 1930, to Feb 13th, 1930,
that I last saw ~~him~~ alive on Feb 12th, 1930,
and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Asthmia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) W S Silverhouse, M. D.

2/14, 1930 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 2/15/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

Dr. W. D. Tarlow 315 S Highland Ave Wolf 2475

E 54074 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54074

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3106 Flert st ST. 1-1 WARD)

2-FULL NAME John Mitchell

(a) RESIDENCE NO. 3106 Flert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec 11th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith 80

(b) General nature of industry, business, or establishment in which employed (or employer) Iron

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John V. Mitchell (Address) 3106 Flert st

15 Filed 2-15-1930 19 Dyer Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 13, 1930, that I last saw him alive on Feb 12, 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Thomas B. Tarlow, M. D.

2-13, 1930 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 2/15/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

B 15 1930

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 54075 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54075

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 14-24 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Plackov

(a) RESIDENCE NO. 1308 Kuper ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Serbia

PARENTS

10 NAME OF FATHER Olympiath ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Serbia

12 MAIDEN NAME OF MOTHER Christina ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Serbia

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed FEB 15 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13-30

17 I HEREBY CERTIFY, That I attended deceased from 2-10-30, 19..., to 2-13-30, 19...,

that I last saw him alive on 2-13-30, 19...,

and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ? yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Xray

(Signed) Marvin M. McKean, M. D.

2-23, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb. 15th 1930

20 UNDERTAKER R. Jones

ADDRESS W. S. Gelien

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 54076 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54076

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 90

CITY OF BALTIMORE: (No. 4-25 ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Bryant

(a) RESIDENCE NO. 109 N. Pine St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Bryant

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Pompey Bigby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13-30

17 I HEREBY CERTIFY, That I attended deceased from 12-28-29, 19..... to 2-13-30, 19 2-11-30

that I last saw her alive on 2-13-30, 19.....

and that death occurred, on the date stated above, at 10:40A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Senile Dementia ?

(duration) ..... yrs. 1/2 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harris [illegible], M. D.

2-13, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 2/15 1929

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 822 N. Schroeder St.

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54077 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54077

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 E Eager Street ST. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary McWilliams

(a) RESIDENCE NO. 424 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25, 144

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 85				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Long Green

(State or country) Balto. Co. Md

PARENTS

10 NAME OF FATHER Michael McWilliams

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Johanna O'Keefe

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Miss Margaret McWilliams

(Address) 600 E. Eager St.

Filed 2/15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14-30

17 I HEREBY CERTIFY, That I attended deceased from 1924, to Feb 14, 1930,

that I last saw her alive on Feb 14, 1930,

and that death occurred, on the date stated above, at 1730 P m.

The CAUSE OF DEATH* was as follows:

Bronchostenosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

2/15, 1930 (Address) 1403 Rastan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stephens, Kingsville

DATE OF BURIAL 2/18/30

20 UNDERTAKER Rita Friedefeld

ADDRESS 914 Greenmount Ave

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54078

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54078

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Arlington Park Apts 27-55 WARD

2—FULL NAME Jennie R. Nathans

(a) RESIDENCE NO. Arlington Park Apts. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Nathans

6 DATE OF BIRTH (month, day, and year) Apr. 17, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) New York. N. Y.

PARENTS

10 NAME OF FATHER Julius Rosenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Marks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Arthur Nathans

(Address) Arlington Park Apts

Filed FEB 15 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13-30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1927, 19 ..., to Feb. 13th, 19 30, that I last saw her alive on Feb. 13th, 19 30 and that death occurred, on the date stated above, at 11.50A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Pemphigoid dermatosis

(duration) ... yrs. 6 mos. ... ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) Eugene Gropper, M. D.

, 19 (Address) 200 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har Sinai Cem.	2/16/1930
20 UNDERTAKER G. B. Sondheim	ADDRESS 118-20 W. Mt. Royal Ave

Spec.—1-12-23—M&T—500 Blks.

E 54079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 VE 54079

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 W. West ST. 23-31 WARD)

2-FULL NAME Frank Howard

(a) RESIDENCE NO. 123 W. West ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~: Lena Howard

6 DATE OF BIRTH (month, day, and year): 1864 unknown

7 AGE: Years 66 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 023

(b) General nature of industry, business, or establishment in which employed (or employer): Hack driver

(c) Name of employer

9 BIRTHPLACE (city or town) West River (State or country) Md

PARENTS

10 NAME OF FATHER: John Howard

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER: Catherine Carter

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address): Lena Howard 123 N. West St

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18/1930

17 I HEREBY CERTIFY, That I attended deceased from 2/5/, 1930, to 2/13/, 1930, that I last saw h~~im~~ alive on 2/13/, 1930, and that death occurred, on the date stated above, at 10.15 p. m.

The CAUSE OF DEATH* was as follows:

Aorta Dilatation; Pulmonary hypostasis; Haemo Plegia; Acidosis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1/23/30

Was there an autopsy? No

What test confirmed diagnosis? Physical & History

(Signed) W. M. Bishop, M. D.

, 19 (Address) 709 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balt. Auburn Cem. DATE OF BURIAL 2/16/1930

20 UNDERTAKER: Samuel Stanley ADDRESS 1708 Bolton

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54080

CERTIFICATE OF DEATH

101-001

E 54080

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 425 Ward)

2-FULL NAME Virginia Barlow

(a) RESIDENCE NO. 633 Vine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fmal	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day and year) Nov 25-1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Henry Parker

11 BIRTHPLACE OF FATHER (city or town) Georgia
(State or country)

12 MAIDEN NAME OF MOTHER Addie Barlow

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Addie Barlow
(Address) 633 Vine st

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

Signed ... M. D.

Feb 24 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	2/17 1930
20 UNDERTAKER Samuel I Hemsley	ADDRESS 578 N Bond

Information should be carefully supplied. Avoid ambiguity. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-002

E 54081

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 Mosher ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary A. Thomas Washington

(a) RESIDENCE NO. 608 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry L. Washington

6 DATE OF BIRTH (month, day, and year): Nov-22-1869

7 AGE: Years 60 | Months 2 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Laundress

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Leesburg Va

PARENTS

10 NAME OF FATHER: Charles Burnside

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Lucy F. Thomas

(Address): 608 Mosher

15 Filed: 1-5-1930, 19 NOH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 18 1930 to Jan 13 1930

that I last saw h[illegible] alive on Feb 13 1930

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart 30 mins

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? By Post Mortem

(Signed) H. C. Bell M. D.

19 (Address) 1321 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 1/16 1930

20 UNDERTAKER: Samuel Steinsky

ADDRESS: 928 E Balto

Important. See instructions on back of certificate.

HAMPSON JONES, M.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54082 — CERTIFICATE OF DEATH — 129 E 54082

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 583 Orchard ST. 17-24 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virginia Johnson

(a) RESIDENCE NO. 583 Orchard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 1st 1865

7 AGE — Years: 64 Months: 8 Days: 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co. Md

PARENTS

10 NAME OF FATHER: Joseph Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Elizabeth Johnson

(Address) 583 Orchard St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1929 to Feb 12, 1930

that I last saw h[illegible] alive on Feb 12, 1930

and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 2/16 1930

20 UNDERTAKER: Samuel E. Hinkle

ADDRESS 578 [illegible]

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54083

CERTIFICATE OF DEATH.

90 E 54083

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 217 N Montford ave (St.) 6-10 (Ward)

2-FULL NAME Arthur Banks

(a) RESIDENCE (No.) 217 N Montford St (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): W

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Julia Banks

6 DATE OF BIRTH (month, day, and year): 1844

7 AGE: 85 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Soldier

(b) General nature of industry, business, or establishment in which employed (or employer): 05

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Md

PARENTS

10 NAME OF FATHER: Moses Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rachael Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Emma Grant

(Address) 217 N. Montford ave

15 Filed 1 5 1930

16 Registered

C. HAMPSON JONES, M. D.

RFH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1930, to Feb 13, 1930

that I last saw him alive on Feb 10, 1930,

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Arterial Hypertension

Senile Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. R. Real M. D.

. 19 (Address) 564 Mellor Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	Feb 16 1930
20 UNDERTAKER	ADDRESS
Robert J Wilkinson	1575 McCulloh St

CAUSE OF DEATH. IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

E 54084

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54084

CERTIFICATE OF DEATH

REGISTERED NO. 45

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2436 E. Preston St. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William T. Dunn

(a) RESIDENCE NO. 2436 E Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katzenberger Dunn Mary G. Dunn

6 DATE OF BIRTH (month, day, and year) Dec. 22- 1870

7 AGE	Years	Months	Days 21	If LESS than 1 day, hrs. or min.
	59	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Martin E. Dunn

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Ellen T. Sheridan

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Mrs. Mary G. Dunn (wife)

(Address) 2436 E Preston.

15 Filed 19 By C. HAMPSON JONES, M. D. Registrar

B 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 13-1930

17 I HEREBY CERTIFY, That I attended deceased from June 13 1929, to February 13 1930

that I last saw ~~him~~ alive on Feb. 12 1930

and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ✓ If not at place of death?

Did an operation precede death? Yes Date of Oct. 11- 1929

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Thos. J. A. Stevens, M. D.

2/14 1930 (Address) 2876 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 2/17 1930

20 UNDERTAKER D. J. Faherty & Sons

ADDRESS 1318 Light

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54085

CERTIFICATE OF DEATH

129 ✓

E 54085

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 11 S Pulaski ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Foley

(a) RESIDENCE NO. 11 S Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

(a) If married, widowed, or divorced WIFE of (or) HUSBAND of James H Foley

6 DATE OF BIRTH (month, day, and year) Feb 15 1862

7 AGE Years 67 Months 11 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER John Gerby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Hess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Margaret Foley

(Address) 11 S Pulaski St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1929, to Feb 10, 1930, that I last saw h alive on Feb 12, 1930 and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Myocarditis Chronic,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ? What test confirmed diagnosis? Clinical Diagnosis

(Signed) E Wells Hemming, M. D.

2/15, 1930 Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 2/15/30

20 UNDERTAKER George A Farley

ADDRESS Fulton & Lafayette

Important: See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54086

E 54086

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 Whalcott St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Etta Williams

(a) RESIDENCE NO. 923 Whalcott St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Williams

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Julia Kent (mother)

(Address) 923 N Whalcott St

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-13-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 30 to 2-13-30

that I last saw her alive on 2-13-30

and that death occurred, on the date stated above, at 4 a, m.

The CAUSE OF DEATH* was as follows: Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H H Cardon M. D.

, 19 (Address) 924 N Whalcott

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Feb. 16, 1930

20 UNDERTAKER Mrs Katie R Williams

ADDRESS 322 N Schroeder St

Important. See instructions on reverse side before writing.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54087

CERTIFICATE OF DEATH

E 54087

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 N Saratoga ST. 15-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maryann H Butler

(a) RESIDENCE NO. 1118 N Saratoga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lambert Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Stinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Louise C Butler
(Address) 1118 Saratoga St

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/13/30

17 I HEREBY CERTIFY, That I attended deceased from August, 1929, to Feb 13, 1930, that I last saw h alive on Feb 13, 1930 and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia - Paralysis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald Dunn, M. D.

2/14, 1930 (Address) 1207 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Feb. 16, 1930

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 321 N. Schroeder St.

Important. See instructions on back of certificate.

FEB 15 1930 C. HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54088 E 54088

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 Hollins 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Steele

(a) RESIDENCE No. 1727 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
77	77	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Robert Steele

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant Ethel Steele
(Address) 1727 Hollins St

15 1930 C. HAMPSON JONES, M. D. Registrar

Reg'r

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb 8, 1930, to Feb 14, 1930, that I last saw him alive on Feb 14, 1930, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) [illegible] M. D.

2/15, 1930 (Address) 54 S Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Feb 17 1930
20 UNDERTAKER	ADDRESS
F Vernon Keehner	532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question must be answered. Write plainly. Use ink. Do not use abbreviations. Every statement must be full and complete. Every certificate must be signed. DEFINITE AND COMPLETE INFORMATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54089

HEALTH DEPARTMENT—CITY OF BALTIMORE

112 E 54089

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4506 Eastern St. 26-37 Ward)

2-FULL NAME Geo. H. Kroll.

(a) RESIDENCE NO. 4506 Eastern St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 6-1911

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	18	9	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Oscar H. Kroll

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Fredrick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna Kroll
(Address) 4506 Eastern Ave

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, aforesaid Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cross of Dist
AC, Intoxication
AC, Cardiac. D.L.

(duration) ... yrs. ... mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam of Urine

(Signed) [illegible], M. D.

. 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cem

DATE OF BURIAL Feb. 16 1930

20 UNDERTAKER George W. Zirkle

ADDRESS 1737 E. Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54090

CERTIFICATE OF DEATH

185 E 54090

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1015 S. Clinton St. 76-1 Ward)

2-FULL NAME Elizabeth Himmelmann

(a) RESIDENCE NO. 1015 S. Clinton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Carl Himmelmann

6 DATE OF BIRTH (month, day, and year) ~~Feb 27/858~~ Apr 15/1850

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71	9	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER ---- Bachmann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Frederick W. Himmelmann
(Address) 4702 Hazelwood Ave (son)

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 13/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Embolism -
Frac lt femur at hip.- Accidently
fell on ice near her home Jan 19th

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital Record

(Signed) [signature], M. D.

2/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL Feb 17 19 30

20 UNDERTAKER George W. Zinkler — ADDRESS 1737 E Eager St

FEB 15 1930

Rec'd

IMPORTANT: Physician, please fill out this certificate carefully, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 54091

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54091

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Arlington ave. 16-23 WARD)

2-FULL NAME James L. Biggs

(a) RESIDENCE No. 905 Arlington ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 25-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER James L. Biggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington, D.C.

12 MAIDEN NAME OF MOTHER Elizabeth McKid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co. Md.

14 Informant Andrew J. Keller

(Address) 905 Arlington ave.

15 Filed FEB 15 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1 —, 1930, to Feb. 13, 1930, that I last saw h— alive on Feb 13, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus -

History one

(duration) 12 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Koons, M. D.

2-14 1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore cemetery

DATE OF BURIAL Feb. 15 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager

TION is very important. See instructions on back of this

Spec.—1-30—M. & T.—250 Blks.

E 54092 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54092

CERTIFICATE OF DEATH.

REGISTERED NO. 122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3113 Fleet (ST.) 1-1 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Vaupel

(a) RESIDENCE NO. 3113 Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Vaupel

6 DATE OF BIRTH (month, day, and year) Dec 24-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Charles Vaupel (Address) 3113 Fleet St.

15 Filed FEB 15 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1. 19 30 to Feb 14 19 30

that I last saw her alive on Feb. 14 19 30

and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver
due to chronic obstruction
of Bile duct.
Arteriosclerosis hrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. Gastritis duration 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Ernst Jenkins M. D.

(Address) 2934 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL Feb 18 1930

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager

ON IS VERY IMPORTANT. See instructions on reverse side for additional space.

Form 6-0-19 H. P. Co. 1000 Blks.

E 54093

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54093

CERTIFICATE OF DEATH.

90

REGISTERED NO. 22-30

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 N. Washington St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann D. Cushell

(a) RESIDENCE. NO. 623 N Washington St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Cushell

6 DATE OF BIRTH (month, day, and year) Sept 1 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Cullen

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Nichol

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mrs. Morgan
(Address) 623 N. Washington St.

15 Filed . C. HAMPSON JONES, M. D. Registrar
By

FEB 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 . 1930 . to Feb 14 . 1930 .
that I last saw her alive on Feb 13 . 1930 .
and that death occurred, on the date stated above, at 12.30 A. m.
The CAUSE OF DEATH* was as follows:

Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Age
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms + age

(Signed) Howard E. Silver, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Feb 17 1930

20 UNDERTAKER: George W. Zickler — ADDRESS: 1737 E Eager st

CAUSES OF DEATH must be stated in plain terms. No abbreviations or ditto marks. See instructions on back of certificates.
TION is very important.

Spec.—8-16-29—L. F. S.—100 Blks.

E 54094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 54094

REGISTERED NO. 1622

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 Mosher ST., WARD)

2—FULL NAME Clarence Emmet Wright,

(a) RESIDENCE NO. 1810 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Elizabeth E. Wright,

6 DATE OF BIRTH (month, day, and year) May 21. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wheelwright

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. C. Wright,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Virginia Gravet,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Elizabeth E. Wright

(Address) 1810 Mosher St

15 Filed FEB 15 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1930, to Feb. 15, 1930, that I last saw h~~im~~ alive on Feb 14, 1930 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.
(Hyper-tension
(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) acute dilatation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? P.E.

(Signed) Thomas E. Todd, M. D.

2/15. 1930 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL FEB 17 1930

20 UNDERTAKER Geo. W. Little

ADDRESS 2700 EDMONDSON AVE.

important. See instructions on back of certificate.

FEB 15 1930

Spec.—2-29-28—L. F. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54095 REGISTERED NO. E 54095

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3728 Foster ave ST., 26-37 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara Buettner

(a) RESIDENCE NO. 3728 Foster Ave ST., 26 WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Frederick Buettner

6 DATE OF BIRTH (month, day, and year) Nov 27 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Preisendorfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jennie M. Muterling (Address) 3728 Foster ave

15 Filed FEB 18 1930, 19 E. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13th/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13, 1929 to Feb 13, 1930. that I last saw h[er] alive on Feb 13, 1930 and that death occurred, on the date stated above, at 11 00 A. m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Disease

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Vincent V. Jaska, M. D.

19 (Address) 845 N. Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Feb 17 1930
20 UNDERTAKER Lilly & Sons	ADDRESS 409 S. Mt. St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54096 — 31 — E 54096

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 537 S. Fulton Ave (WARD) 28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Zimkoff

(a) RESIDENCE NO. 537 S. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie Zimkoff

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Zimkoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lottie Zimkoff

(Address) 537 S. Fulton Ave

15 FILED FEB 16 1930 16 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15/30

17

I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 15, 1930, that I last saw him alive on Feb 14, 1930 and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

14 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. Katiw Sputum

(Signed) [illegible], M. D.

2/16, 1930 (Address) 223 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem — DATE OF BURIAL 2/16 1930

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

Spec.—8-16-29—L. F. S.—100 Blks.

E 54097 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 E 54097

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 5-58

CITY OF BALTIMORE: (No. 2811 Rockrose ave ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Wiener

(a) RESIDENCE NO 2811 Rockrose ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Wiener

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE — Years: 67 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DICEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Eli Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Herman Wiener
(Address) 2811 Rockrose

15 Filed 8/16 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/15/30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1929, to Feb. 15th, 1930, that I last saw h[illegible] alive on Feb. 15th, 1930 and that death occurred, on the date stated above, at 12:28 m.

The CAUSE OF DEATH* was as follows:

Medical Insufficiency

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Embolism

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Was Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Eugene Kaspar, M. D.

2/15, 1930 (Address) 705 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run — DATE OF BURIAL: 2/16 1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 54098

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-801

E 54098

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital St. 5-8 (Ward)

2-FULL NAME Allan Lowenstein

(a) RESIDENCE NO. 212 Aisquith St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 17-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Lowenstein

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Rosenblatt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant Harry Lowenstein
(Address) 212 Aisquith St.

Filed FEB 16 1930 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930 to 2-14, 1930
that I last saw him alive on 2-14, 1930
and that death occurred, on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos Three ds.

CONTRIBUTORY [redacted] (duration) yrs. mos. [redacted] ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-12-30

Was there an autopsy? Yes Principal Pathological Findings Bronchopneumonia

What test confirmed diagnosis?

(Signed) Samuel J. Stumpfin M. D.

2 Feb. 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shek Sholem [redacted]

DATE OF BURIAL 2/16 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54099 — CERTIFICATE OF DEATH. — 129 — E 54099

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402-E-39 St. 12-49 Ward .....

2-FULL NAME Harry Oscar Perry

(a) RESIDENCE NO. 402 E-39 St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ~ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Essie A Perry

6 DATE OF BIRTH (month, day, and year) Jany 16-187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	0	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) Preston
(State or country) Md

PARENTS
10 NAME OF FATHER Capt Wm Henry Perry
11 BIRTHPLACE OF FATHER (city or town) Caroline
(State or country) Md
12 MAIDEN NAME OF MOTHER Emelia S. Wright
13 BIRTHPLACE OF MOTHER (city or town) Caroline
(State or country) Md

14 Informant Capt Wm Perry
(Address) 402 E. 39.

Filed FEB 16 1930 — C. HAMPSON JONES, M. D. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 5th 1929, to Feby 14th 1930,
that I last saw him alive on Feby 14th 1930,
and that death occurred, on the date stated above, at 12-15 P m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 9 yrs. ~ mos ~ ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 2 yrs. ~ mos. ~ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Douglas M. D.

2/11, 1930 (Address) 3043 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

UNDERTAKER H. Blackwell Son

DATE OF BURIAL Feb 17 1930

ADDRESS Mt Royal Ave.

FOR USE OF REGISTRAR ONLY. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 54100 REGISTERED NO. E 54100

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST. 1350 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Celeste E. Langley

(a) RESIDENCE NO. Home for Incurables ST. 40 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 8-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James Langley

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co. Maryland

12 MAIDEN NAME OF MOTHER Ellen Dunbar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Mary's Co. Maryland

14 Informant Hospital Records

(Address) Home - Keswick Rd -

15 Filed FEB 16 1930, 19 HAWOOD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to Feb. 15, 1930.

that I last saw h[illegible] alive on Feb. 14, 1930

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchs-Pneumonia

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) none S.L. cold & gradual upset.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) H. S. Willis, M. D.

. 19 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb. 17, 1930

20 UNDERTAKER Wm. J. Tickner & Son

ADDRESS N. & Pa. Ave.

Important. See instructions on reverse side.

Spec.—1-30—M. & T.—250 Blks.

E 54101 ✓ E 54101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 517 Edgewood ST. 20-20 (WARD)

2-FULL NAME Andrew Dawson Alexander

(a) RESIDENCE NO. 517 Edgewood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 18 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Ob

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer Eaton

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Alexander

11 BIRTHPLACE OF FATHER (city or town) Eastern (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Alexander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Bessie McCauley (Address) 517 Edgewood St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14-1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 10, 1929, to Feb. 14, 1930,

that I last saw him alive on Feb. 13, 1930,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Chronic nephritis (duration) 4 or 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) M B Burman Wood, M. D.

2/15 1930 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb 17 1930

20 UNDERTAKER H. J. Tedmen Sons

ADDRESS N. Y Pa

TION is very important. See instructions on back of this sheet.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Geo. 16E002 ✓ 54102

E 54102

REGISTERED NO. 16E 54102

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 945 Hanford Ave St., 10-14 Ward)

2-FULL NAME Mary M. Gee

(a) RESIDENCE NO. 945 Hanford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1 30

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Chapel Gee

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Bernice Carter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Chapel Gee
(Address) 945 Hanford Ave

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Birth Injury

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos D Faller, M. D.

2/15, 1930 (Address) 508 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL Feb 17 30

20 UNDERTAKER Dennis Carter | ADDRESS Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 901

E 54103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. En route to University Hospital

2-FULL NAME Willie Lanier

(a) RESIDENCE NO. 917 W. Mulberry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Edna Johnson
(Address) 84 W. Saratoga St

15 Filed ... 19...

C. HAMPSON JONES, M. D.
Registrar

FEB 6 1930

Mayne

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

1/11. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2-16 1930
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Gay ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54104

CERTIFICATE OF DEATH

131 E 54104

1—PLACE OF DEATH Church Home + Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. Broadway + Fairmount (STREET OR AVENUE) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Priborsky

(a) RESIDENCE NO. 1919 E. Eager St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	W	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Ladislaw Priborsky

6 DATE OF BIRTH (month, day, and year) Aug 2, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	6	11	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Czecho-Slovakia

PARENTS

10 NAME OF FATHER Ferdinand Josephek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czecho-Slovakia

12 MAIDEN NAME OF MOTHER ??? Marie Josephek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czecho-Slovakia

14 Informant Garfield Priborsky

(Address) 2430 Ashland Ave.

15 Filed FEB 16 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 13/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1930, to Feb 13, 1930, that I last saw her alive on February 13, 1930 and that death occurred, on the date stated above, at 5 20 p.m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Feb 13, 1930

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. J. E. Akelaitis, M. D.

, 19 (Address) Church Home + Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL Feb. 17 1930

20 UNDERTAKER Frank Grach Son 1906 — ADDRESS Ashland Ave

Important: See instructions on back of certificate

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54105

CERTIFICATE OF DEATH

74-001

E 54105

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 S Ensley ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stephan Simeton

(a) RESIDENCE NO. 133 S. Ensley ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Simeton

6 DATE OF BIRTH (month, day, and year) Dec. 24 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe-maker

(b) General nature of industry, business, or establishment in which employed (or employer) 088

(r) Nsme of employer

9 BIRTHPLACE (city or town) Russia (State or country) Czecho-Slovakia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czecho-Slovakia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Anna Simeton

(Address) 133 Ensley St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 14, 1930, that I last saw h.e alive on Feb. 13, 1930, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. 4 mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. unknown

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank Famiglietti, M. D.

, 19 (Address) 2431 Fait Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 17 1930
20 UNDERTAKER	ADDRESS
Fant Coachbuilding 1906 E Ward St	

Important: See instructions on the back of this certificate

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54106

CERTIFICATE OF DEATH

10-001

E 54106

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N Patterson Pk ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ceston Skrivan

(a) RESIDENCE NO. 213 N Patterson Pk ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Skrivan

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece Slavonia

PARENTS

10 NAME OF FATHER Joseph Skrivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece-Slavonia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Frank Skrivan

(Address) 213 N Patterson Pk

15 Filed ..... 19 ..... Registrar

FEB 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16/30

17 I HEREBY CERTIFY, That I attended deceased from 7-24-29 to 2-16-30, 19..., that I last saw h... alive on Feb 15 1930 and that death occurred, on the date stated above, at 8:10 A m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) F. F. Schneeberg M.D.

2-16 1930 (Address) 80 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Feb. 18 1930

20 UNDERTAKER Frank Swartz

ADDRESS 1906 Eutaw

Spec.—8-16-29—L. F. S.—100 Bks.

E 54107

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54107

CERTIFICATE OF DEATH

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 430 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Ent Merceron

(a) RESIDENCE NO. 203 Allegany Ave. ST. Allegheny WARD Towson, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank G. Merceron

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER John Wright

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Jane Jenkins.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Co. Md.

14 Informant Mr. Henry J. Merceron
(Address) 903 University Parkway.

15 Filed FEB 16 1930 [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-15-30

17 I HEREBY CERTIFY, That I attended deceased from 2-14-30, 19..., to 2-15-30, 19..., that I last saw h[illegible] alive on 2-15-30, 19..., and that death occurred, on the date stated above, at 6 20 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency & mitral regurgitation; Diabetes mellitus

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) myocardial insufficiency

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leroy S. Hech, M. D.

2-15, 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cemetery

DATE OF BURIAL 2/17/30

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert St.

Important. See instructions on back of certificate.

Eugene Pillsbury, D. Comm. W.D.

OK 2/37

Spec.—2-29-28—L. F. S.—500 Bks.

Prock.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54108

E 54108

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 121 N. Exeter Street (ST.) 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia Prock

(a) RESIDENCE NO. 121 N. Exeter St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: Samuel Prock

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 67 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs Prock

(Address) 121 N. Exeter st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-15-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Feb 15, 1930, that I last saw h[er] alive on Feb. 15, 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Old mitral insufficiency

Increasing myocardial insufficiency

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac + renal insufficiency (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Frank R. Smith Sr, M. D.

2/16, 1930 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Int Carmel

DATE OF BURIAL: 2/16 1930

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 E Balto St

FEB 16 1930 HARRY JONES, M. D.

Spec.—2-29-28—1c. F. S.—500 Bks.

E 54109 ✓ E. 54109

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54109 11-002 E 54109

CERTIFICATE OF DEATH

REGISTERED NO. 14-20

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Park Ave. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Oscar Edward Smith

(a) RESIDENCE NO. 1500 Park Ave. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

6a If married, widowed, or divorced BUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apl. 1, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Mfgr.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Henry Smith Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Augusta Stoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundle Maryland

14 Informant: Henry Smith

(Address) 1510 Park Ave.

15 Filed FEB 16 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to February 12, 1930.

that I last saw him alive on February 12, 1930

and that death occurred, on the date stated above, at 7:00P m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Pleurisy, Myocarditis and acute Cardiac Dilatation yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical & Physical findings & Chest

(Signed) Frank S. Hundley, M. D.

19 (Address) 2512 Maryland Ave.

Co: State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb 17 1930

20 UNDERTAKER: Hughes & Bruce Inc

ADDRESS: 424 N. Broadway

✓ E. 54110

Spec—12-23-21—E.B.P.S.—400 Blks.

E 54110 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 54110

CERTIFICATE OF DEATH.

91-002

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2905 Alameda Blvd 9th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolina J. Holman

(a) Residence No. 2905 Alameda Boulevard Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Frederick W. Holman

6-DATE OF BIRTH (month, day and year) Aug. 6. 1873

7-AGE. 56 yrs. 5 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER John Baumschmidt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER Mary Kestler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-Informant Frederick W. Holman

(Address) 2905 Alameda Boul.

15-

Filed FEB 16 1930 C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Feby. 13-30

I HEREBY CERTIFY, That I attended deceased from June 15th 1929 to Feby 13th 1930.

that I last saw h[e]r alive on Feby 12th 1930.

and that death occurred, on the date stated above, at 7a. m.

The CAUSE OF DEATH* was as follows:

Uremia - Gallstones

Unknown (Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Signs Etc

What test confirmed diagnosis?

(Signed) Frederick D. Olsen M. D.

, 19 (Address) 2827 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Feb 18 1930

20-UNDERTAKER. William H. Schaffer ADDRESS 1816 Mount

B

instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

W. affeld C. 54111

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54111

CERTIFICATE OF DEATH.

90 E 54111

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2813 W. North Ave St.) 15-68 (WARD)

2-FULL NAME Sabilla Reed

(a) RESIDENCE NO. 2813 W. North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Frank B. Reed

6 DATE OF BIRTH (month, day, and year) April 12, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
72		10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Daniel B. Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Polly Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Mrs. Frank B. Wolfe

(Address) 2813 W. North Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to Feb 14, 1930, that I last saw h.. alive on Feb. 13, 1930, and that death occurred, on the date stated above, at 8.20 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. R. Wolfe, M. D.

2/14/30 (Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Penna — DATE OF BURIAL Feb 17 1930

20 UNDERTAKER Wm Cobb — ADDRESS 1217 Hanover

FEB 17 1930 HUNTER JONES, M. D. Registrar

Spec.—1-10-21—M&T—1500 Bks.

E 54112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

144

E 54112

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 25 WARD)

2-FULL NAME Ellis C. Williams

(a) RESIDENCE NO. 115 N. Mulberry St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Thelma Williams

6 DATE OF BIRTH (month, day, and year) 2/4/1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self N. C.

9 BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10 NAME OF FATHER James Williams N. C.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Martha Griffis

13 BIRTHPLACE OF MOTHER (city or town) N. C. (State or country)

14 Informant Mrs. Thelma Williams (Address) 115 N. Mulberry St.

15 Filed FEB 17 1930 C. HA[illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/14/ 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-12 1930 to 2-14 1930.

that I last saw him alive on 2-14 1930,

and that death occurred, on the date stated above, at 3 a.m. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach
Cardiac end

(duration) 3 yrs. mos da.

CONTRIBUTORY .....
(Secondary)
..... (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? yes Date of 2-12-30

Was there an autopsy? no

What test confirmed diagnosis? Frozen section

(Signed) Ernest Spencer Jr. M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monroe City Union Country N.C. DATE OF BURIAL 2/17 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

CAUSE OF DEATH must be plainly written, so that it may be read as it is recorded. See instructions on back of certificates. TION is very important

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 E 54113 — E 54112

CERTIFICATE OF DEATH

REGISTERED NO. 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Neilson

(a) RESIDENCE NO. 1388 W. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Nov 15th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Mass

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary E Cotter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass

14 Informant: Unknown

(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 17 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930, to Feb 15, 1930, that I last saw her alive on Feb 15, 1930 and that death occurred, on the date stated above, at 5.20 A m.

The CAUSE OF DEATH* was as follows:

Septicaemia

Infected foot - Pyaemia

Multiple Renal abscess

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetic acidosis

Diabetes (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy. Bl. Culture

(Signed) Hedwig Kouns, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: 2/11/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54114

CERTIFICATE OF DEATH

74-001

E 54114

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 W. Cross ST. 21 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helena Lettau

(a) RESIDENCE NO. 1208 W. Cross ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widowed

5a If married, widowed, or divorced (or) WIFE of Bernhardt A. Lettau

6 DATE OF BIRTH (month, day, and year) July 10, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer S. of P.

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Louise Reese

(Address) 1208 W. Cross St.

15 Filed FEB 17 1930. C. HARRISON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to February 15, 1930, that I last saw her alive on February 14, 1930 and that death occurred, on the date stated above, at 11⁰⁰ A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

Feb 15, 1930 (Address) 1319 Light St, Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 2/18/1930

20 UNDERTAKER Wm Cook 1217 St Paul St

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54115

REGISTERED NO. E 54115

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 54115

1-PLACE OF DEATH

City of Baltimore: (No.) 2214 Poplar (St.) 15-60 (Ward)

2-FULL NAME Jacob Hark

(a) RESIDENCE NO. 2214 Poplar St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | Color or Race: White | Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, widowed, or divorced— HUSBAND of (or) WIFE of Elizabeth.

6 DATE OF BIRTH (month, day, and year) May 2-1838

7 AGE: Years 71 | Months 9 | Days 14 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant F. Ralph Whitby
(Address) 2214 Poplar St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ... death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. Bloomfield, M. D. Coroner

Feb 16 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 2/19/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 54116 HEALTH DEPARTMENT—CITY OF BALTIMORE

Kallenbyer 1729 West Lombard

CERTIFICATE OF DEATH.

E 54116

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave (ST.) 25-12 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Jones

(a) RESIDENCE NO. Linthicum Heights ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12-5-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER J. Morris Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Michaels Md

12 MAIDEN NAME OF MOTHER Daley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Thos M Jones (Address) Linthicum Heights Md

15 Filed FEB 17 1930, 19 C. HA... JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-15 1930

17 I HEREBY CERTIFY, That I attended deceased from 8-14, 1930, to 8-15, 1930, that I last saw her alive on 8-15, 1930, and that death occurred, on the date stated above, at 1 55 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) J. D. Kallenbyer M.D.

2/16, 1930 (Address) 1729 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 2/18/1930

20 UNDERTAKER Wm Cook — ADDRESS 127 St Paul St

CAUSE OF DEATH must be filled in. All items must be answered. See instructions on back of certificates.

Spec.—1-30—M. & T.—200 Blks. Dr. Sandrock Medical Arts Bldg

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54117

E 54117

CERTIFICATE OF DEATH.

29

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3900 Old York Rd (Street) 12-44 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Emma Jane Stouffer

(a) RESIDENCE NO. 3900 Old York Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Daniel P. Stouffer

6 DATE OF BIRTH (month, day, and year) 5/9/1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Lloyd Oliver McCubbin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Randolph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Daniel P. Stouffer (Address) 3900 Old York Rd

Filed FEB 17 1930 C. HAMPTON JONES, M. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930 to Feb 17, 1930

that I last saw h~~er~~ alive on Feb 17, 1930

and that death occurred, on the date stated above, at 2:10 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar P. Sandrock M. D.

, 19 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 2/17/1930

20 UNDERTAKER D. Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54118

E 54118

CERTIFICATE OF DEATH.

REGISTERED NO. 160

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (NO.) 2244 Cedley ST. 25-32 WARD

2-FULL NAME Infant ~~Mrs.~~ Mrs. Walter Soetze

(a) RESIDENCE NO. 2244 Cedley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1930

7 AGE — Years | Months | Days | If LESS than 1 day, 8 hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Soetze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schwab

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Walter Soetze (Address) 2244 Cedley St.

15 Filed FEB 7 1930 19 C. HARRY JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1930 to Feb 15, 1930 that I last saw h.im alive on Feb. 14, 1930 and that death occurred, on the date stated above, at 7:45 A. m.

The CAUSE OF DEATH* was as follows: I a

Congenital Debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Eclampsia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

Signed) H. S. Campbell M. D.

2/15 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys (Hampden) Cemetery — DATE OF BURIAL 2/17/1930

20 UNDERTAKER: John Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54119

E 54119

E 54119

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 8-13 Ward)

2-FULL NAME Leamer Brooks

(a) RESIDENCE NO. 2013 Ellsworth St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Brooks

6 DATE OF BIRTH (month, day, and year) Jan 2/1865

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	65	1	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lancaster, Pa.

PARENTS

10 NAME OF FATHER Peter Cline

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Elizabeth Rivel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Leamer Myers
(Address) 2013 Ellsworth St.

15 Filed 19 Registrar

EB 17 1930

C. HAMILTON JAMES, M. D.

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Streptococcic Meningitis - Probable fracture of skull at base- nasal region (No X-Ray) Fell in home Feb 12/30. Accidental (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. Spinal Fluid

(Signed) [signature], M. D.

2/15/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	2/17/1930
20 UNDERTAKER Wm Cook	ADDRESS 127 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54120 90 ✓ E 54120

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 831 Harlem Ave 46-26 WARD)

2—FULL NAME Alonzo J. Mazer

(a) RESIDENCE NO. 831 Harlem Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 10 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 2-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Royal Cab Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John F. Mazer

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Maggie A. Clutts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Maggie A. Mazer (Address) 831 Harlem ave

15 Filed FEB 17 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930, to Feb 14, 1930, that I last saw h[illegible] alive on Feb 14, 1930, and that death occurred, on the date stated above, at 2,35 A. m.

The CAUSE OF DEATH* was as follows: Cardiac Dilation Edema

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Thomas, M. D.

Feb 16 1930 (Address) 712 S. Mary Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary

DATE OF BURIAL 2-17 1930

20 UNDERTAKER John W. Trodden

ADDRESS 1027 Hanover

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54121 ✓ E 54121

CERTIFICATE OF DEATH

109-002

E 54121

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Church Homr & Infirmary St. 26-41 Ward)

2-FULL NAME Julius C. Skrakowski

(a) RESIDENCE NO. 4203 Heckel Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	whiye	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18/1929

7 AGE	Years	Months	Days 2	IF LESS than 1 day hrs. or min.
		11	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Michael Skrakowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Sobus

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Father
(Address) 4203 Heckel Ave

15 FEB 17 1930 D. C. HAMPSON JONES, M. D.
Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Peritonitis-Streptococcic

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Tonsilitis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? yes Date of Drainage

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/15/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Feb

DATE OF BURIAL 17 1930

20 UNDERTAKER John M Weber

ADDRESS 1112 Chester

20

OF DEATH in plain terms, so that it may be properly classified. Have answers important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 54122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 54122

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 1-3 ST., WARD)

2-FULL NAME Dominick Sobolewski.

(a) RESIDENCE NO. 510 S. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frances Sobolewski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59(?)	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None for 4 yrs. 0 0

(b) General nature of industry, business, or establishment in which employed (or employer) formerly John Land.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland.

PARENTS

10 NAME OF FATHER Joseph (James?) Sobolewski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Gertrude ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Records ?
(Address) BALTIMORE CITY HOSPITALS

15 Filed FEB 17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3, 1930, to Feb 15, 1930, that I last saw h living on Feb 15, 1930, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic
more than 2 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Myocarditis, Chronic
more than 2 yrs. mos. ds.
(duration)

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam; lab

(Signed) Paul Padget. M. D.

Feb. 16 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary, Feb.

DATE OF BURIAL 19 1930

20 UNDERTAKER John M Corbett & Sons

ADDRESS Chester

200

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54123

E 54123

CERTIFICATE OF DEATH.

V101

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 McCulloh St. 20 WARD)

2-FULL NAME Mary Berry

(a) RESIDENCE NO. 1611 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Berry

6 DATE OF BIRTH (month, day, and year) Sept 16 - 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Grandson Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nancy Roots

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Nannie Jackson (Address) 1611 McCulloh

15 Filed ..... 19 ..... Registrar C. HARRISON JONES, M. D.

DEC 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 - 16 - 1930

17 I HEREBY CERTIFY, That I attended deceased from 2 - 13 - 1930 to 2 - 16 - 1930, that I last saw h[illegible] alive on 2 - 15 - 1930, and that death occurred, on the date stated above, at 1:46 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Influenza (duration) ..... yrs. ..... mos 3 ..... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of --

Was there an autopsy? Yes

What test confirmed diagnosis? History & Physical Diagnosis

(Signed) John Calyan, M. D.

, 19 (Address) 1433 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 12/17/1930

20 UNDERTAKER Wm. Geo. H. Holland — ADDRESS 1631 Madison Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—7500 Blks.

54124

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hosp.

REGISTERED NO. 54124

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) S 13-59 WARD

2-FULL NAME Harry Gerber

(a) RESIDENCE NO. 2004 Bryant Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Gerber

6 DATE OF BIRTH (month, day, and year): July 15-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Pacus Gerber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Ida Gerber (Address) 2004 Bryant Ave

15 Filed 2/17 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/16 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930, to Feb 16, 1930, that I last saw him alive on Feb 16, 1930, and that death occurred, on the date stated above, at 3:25 P.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Facts

(Signed) Jacob H Conn M. D.

2/16, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hebrew Rest

DATE OF BURIAL: 2/19 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balt St

CAUSE OF DEATH must be given. See instructions on back of certificates. PHYSICIAN is very important.

617 1930

Spec.—2-29-28—L. P. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 54125

1—PLACE OF DEATH

REGISTERED NO. E 54125

CITY OF BALTIMORE: (No. 2424 E. Chase ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vincent L'Onofrio

(a) RESIDENCE NO. 2424 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy L'Onofrio

6 DATE OF BIRTH (month, day, and year) July 22 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53.	6	5.	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Anthony L'Onofrio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Louisa Minelli

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph L'Onofrio (Address) 2424 E. Chase St.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb. 15, 1930, that I last saw him alive on Feb. 15, 1930 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical tests.

(Signed) Albert Singuraco M. D.

2/17, 1930 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Feb 19 1930
20 UNDERTAKER Kendall J. Lupp	ADDRESS 300 S. Eden

Important: See instructions

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54126

178 ✓ E 54126

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Church Home & Infirmary St. 3-4 Ward)

2-FULL NAME John Tagg

(a) RESIDENCE NO. 503 S. Spring St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24/25

7 AGE	Years	Months	Days	*IF LESS than 1 day ..... hrs. or ..... min.
	4	7	21 20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER William Tagg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Gusta Schmidt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Gusta Tagg
(Address) 503 S. Spring St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns over entire body. Home caught from overheated wood stove
Accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ..... M. D.

2/17/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem. DATE OF BURIAL Feb 17 1930

20 UNDERTAKER Wendell J Dippel ADDRESS 3003 Eden St

OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 54127

90 E 54127

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2218. Bethel ST. 3-4 WARD)

2-FULL NAME Sarah Davis

(a) RESIDENCE NO. 2218 S. Bethel. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Davis

6 DATE OF BIRTH (month, day, and year) May 7. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min
	55.	9.	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Chase

11 BIRTHPLACE OF FATHER (city or town) Cambridge Md
(State or country)

12 MAIDEN NAME OF MOTHER Sat Brown

13 BIRTHPLACE OF MOTHER (city or town) Cambridge
(State or country)

14 Informant Mary Davis 2218 E Bethel St.
(Address)

15 Filed FEB 17 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-15 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-1-1930, to 2-15-1930, that I last saw h alive on 2-14-1930 and that death occurred, on the date stated above, at 9.30 A. m

The CAUSE OF DEATH[a] was as follows:

Chronic Valvulets

(duration) unknown yrs. mos ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm H Cargill, M. D.

2-15 1930 (Address) 611 N. Carolin

[a]State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ashury Cemetery	Feb. 18. 1930
20 UNDERTAKER Wendell J Cropper	ADDRESS 300 N Calvin

CAUSE OF DEATH IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54128

E 54128

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver STS 9-17 WARD)

2-FULL NAME Clara ~~Mc~~ Griffith

(a) RESIDENCE NO. Whiteford Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 3 ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Griffith.

6 DATE OF BIRTH (month, day, and year) [illegible] 77

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanford Co Md.

PARENTS

10 NAME OF FATHER Robert E. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillah [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant W. L. Webb
(Address) Town Hill Rd

15 Filed ... 1930 C. HAMPSON JONES, M. D. Registrar

Out

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930 to Feb. 17, 1930, that I last saw her alive on Feb. 17, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Caecum

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) N B Kennedy, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Val

DATE OF BURIAL Feb 18 1930

20 UNDERTAKER W. L. Webb

ADDRESS Town Hill Rd

CAUSE OF DEATH in plain terms. So that it may be properly TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 54129

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54129

E 54129

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1658 Gorsuch Ave. WARD 9-46)

2-FULL NAME Dorothy Lee Kelley

(a) RESIDENCE NO. 1658 Gorsuch Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Oct 1 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas W. Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Margaret E. Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Father) Thomas W. Kelley

(Address) 1658 Gorsuch Ave

15 Filed FEB 7 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930 to Feb 15, 1930,

that I last saw h alive on Feb 15, 1930,

and that death occurred, on the date stated above, at 8.20 p m.

The CAUSE OF DEATH* was as follows:

Influenza Meningitis

(duration) yrs. mos 1 ds.

Bronchopneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Frederick L. Kerner, M. D.

Feb 16, 1930 (Address) 1301 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb 8 1930

20 UNDERTAKER: Elmer W. Conklin

ADDRESS: 924 E Eager St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Wilz

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54130

CERTIFICATE OF DEATH.

24 801

E 54130

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 Linwood Av., WARD) 3

2-FULL NAME Henry Wilz Sr.

(a) RESIDENCE NO. 739 Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Wilz

6 DATE OF BIRTH (month, day, and year) June 9-1850

7 AGE	Years	Months	Days 7.	If LESS than 1 day, hrs. or min.
	79	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker #3

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Baden

PARENTS

10 NAME OF FATHER John Adam Wilz

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary E. Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Wilz (Address) 739 Linwood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1929, to Feb 16, 1930, that I last saw h.. alive on Feb 16, 1930, and that death occurred, on the date stated above, at 11.90 a m.

The CAUSE OF DEATH* was as follows:

Paralysis. Hemorrhage of Brain

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Hardening of Arteries (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. G. Rocaro, M. D.

2/16 1930 (Address) 2409 Fairmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Feb 19 1930

20 UNDERTAKER George W Zirkler — ADDRESS 1737 Eager St.

FEB 17 1930

Spec.—1-10-21—M&T—1500 Bks.

Groft

E 54131

E 54131

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) St Joseph's Hospital WARD

2-FULL NAME Dorothy Groft

(a) RESIDENCE NO. 2025 Woodbury Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2yrs yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child.

6 DATE OF BIRTH (month, day, and year) Nov 23, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Lawrence Groft.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Helen Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Helen Groft.

(Address) 2025 Woodbury Ave

15 (Filed) FEB 17 1930 H. HARRISON KNIGHTS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 24 Feb 30

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930, to Feb 15, 1930, that I last saw h[illegible] alive on Feb 15, 1930 and that death occurred, on the date stated above, at 3 30 P.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos. 9 da

CONTRIBUTORY (Secondary) Cardiac Dilatation sudden

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of not

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) N B Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster — DATE OF BURIAL Feb 18 1930

20 UNDERTAKER Chenoweth & Son — ADDRESS 3605 Clinton Ave

CAUSE OF DEATH must be given. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54132

CERTIFICATE OF DEATH.

11 ✓ E 54132

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W' Balto. Gen. Hosp. St. 21-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. James E. Kyne.

(a) RESIDENCE NO. 1529 Ridgely Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Birdie Kyne

6 DATE OF BIRTH (month, day, and year) Feb 9 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass. Blower 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James E Kyne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Birdie Kyne (Address) 1529 Ridgely Ave

15 Filed FEB 17 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1930, to Feb. 15, 1930, that I last saw h[illegible] alive on Feb. 15, 1930 and that death occurred, on the date stated above, at 2.55 A. m

The CAUSE OF DEATH* was as follows: Acute Appendicitis (Ruptured)

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Feb. 2, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) S. A. Klein, M. D.

, 19 (Address) W. Balto Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2-18 1930

20 UNDERTAKER Bernard C. Harke, 1000

ADDRESS S. Paca St

TION is very important See instructions on back of certificate

EB 17 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54133

CERTIFICATE OF DEATH

E 54133

74-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (ST.) 117-44 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Meakins

(a) RESIDENCE NO. 3800 Tudor Hall Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice McCrae

6 DATE OF BIRTH (month, day, and year) Jan. —, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Lumber Mercht

(b) General nature of industry, business, or establishment in which employed (or employer) Ret'd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Samuel Meakins

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Irene

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm. F. Meakins

(Address) 3701 Barrington Road

15 Filed FEB 17 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 14, 1930

that I last saw h IM alive on Feb 14, 1930

and that death occurred, on the date stated above, at 1:10 P.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage, intra-Cranial, with Hemiplegia, Lft. complete

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff— generalized Art. Scl (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Hooper M. D.

2-14 1930 Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	Feb. 17, 1930
20 UNDERTAKER John J. Mitchell Son Wm. Mitchell	ADDRESS 1700 Eutaw Place

Spec.—1-30—M. & T.—250 Blks.

E 54134 HEALTH DEPARTMENT—CITY OF BALTIMORE 49VE 54134

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto City Hosp. 2-4
CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

2-FULL NAME John Stalkamp

(a) RESIDENCE NO. 116 S Chapel ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma Stalkamp

6 DATE OF BIRTH (month, day, and year) ..... ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63?	—			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman 66
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS
10 NAME OF FATHER Frank Stalkamp
11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Germany
12 MAIDEN NAME OF MOTHER Anna ?
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Germany

14 Informant ..... (Address) Balto City Hosp. Russ.

15 Filed ..... 19..... E. MAGRUDER HAYES, M. D. Registrar

FEB 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-15-1930

17 I HEREBY CERTIFY, That I attended deceased from 2-13, 1930, to 2-15, 1930, that I last saw him alive on 2-15, 1930, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of urinary bladder.

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Unknown
(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? None
Was there an autopsy? No
What test confirmed diagnosis? Physical Examination
(Signed) Fred M. Dudenhall, M. D.
, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel — DATE OF BURIAL Feb 18 1930

20 UNDERTAKER Louis Heimann — ADDRESS 329 S Broadway

Spec.—1-12-23—M&T—500 Blks.

E 54135 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 54135**

155 v

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1807 Belt. ST. 24-3d WARD)

2-FULL NAME Dimitri Atroshka.

(a) RESIDENCE NO. 1807 Belt. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs mos ds. How long in U. S., if of foreign birth? 20 yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Atroshka

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore & Ohio. RR

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Martha Atroshka. (Address) 1807 Belt. St.

15 Filed . . 19 C. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to Feb 15, 1930 that I last saw h alive on Feb 15, 1930 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Mania

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Sepsis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Campbell M. D.

2/16, 1930 (Address) 1644 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Russian Independent Rem. DATE OF BURIAL Feb 18 1930

20 UNDERTAKER John Grabianckas ADDRESS 423 S. Eden St

THIS IS VERY important. See instructions

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54136 146 **E 54136**

CERTIFICATE OF DEATH

26-42

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Josephs Hospital St. ..... Ward)

2-FULL NAME JENNIE RASPE

(a) RESIDENCE NO. 6229 Belair Road St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles W. Raspe

6 DATE OF BIRTH (month, day, and year) June 29th, 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	34	7	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town) Sussex County
(State or country) Delaware

PARENTS

10 NAME OF FATHER Charles H. Tull

11 BIRTHPLACE OF FATHER (city or town) Gailstown
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Smith

13 BIRTHPLACE OF MOTHER (city or town) Sussex Co.
(State or country) Delaware

14 Informant Charles W. Raspe
(Address) 6229 Belair Road

15 Filed FEB 7 1930 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia (Puerpal) Abortion on 12th 31/2 mons gestation. (Accidental)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? yes Date of Feb 14/30

Was there an autopsy? No (retained placenta)

What test confirmed diagnosis? .....

(Signed) J. H. Callan M. D.

2/16-30 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Cemetery

DATE OF BURIAL Feb. 18 1930

UNDERTAKER Frederick Lassahn & Son

ADDRESS Fullerton

This should be filled out, so that it may be properly classified. Exact statements are important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54137

E 54137

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: NO. Caton & Wilkens Avenue ST. 18-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Konstant

(a) RESIDENCE NO. 857 Hollins St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Demitros Konstant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Greece

14 Informant Son - Theodore Konstant

(Address) 857 Hollins St

15 Filed FEB 17 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-15 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-2, 1930, to 2-15, 1930, that I last saw h alive on 2-15, 1930, and that death occurred, on the date stated above, at 1.55 p m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Aortitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brawner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 2/17/1930

20 UNDERTAKER John J Cowan & Son

ADDRESS 901 Hollins St

CAUSES OF DEATH. See instructions on back of certificates. ATTENTION is very important

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

24-001

E 54138

E 54138

CERTIFICATE OF DEATH

REGISTERED NO. 1928

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 S Calhoun ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F Dimeler

(a) RESIDENCE NO. 418 S Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 8 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE of~~ the late Emma Dimeler

6 DATE OF BIRTH (month, day, and year) May 27th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	8	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sobd. O&O

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Dimeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimd.

14 Informant Mr Geo L Dimeler

(Address) 2810 Frederick Ave

15 Filed FEB 7 1930 19 C. HAMPSON JONES, Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Febry 14th 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb. 14, 1930,

that I last saw him alive on Feb. 13, 1930

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 5 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) John A. Buchmeier, M. D.

19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Luthern Cem Catonsville md.

DATE OF BURIAL 2/18/1930

20 UNDERTAKER John F Cowan & Son.

ADDRESS 901 Hollins St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54139

CERTIFICATE OF DEATH

109-002

E 54139
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 19 N. Caroline St St. 64 Ward)

2-FULL NAME Mary Lewis

(a) RESIDENCE NO. 19 N. Caroline St., Ward Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	IF LESS than 1 day, ...hrs. or ...min.
about 25	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work odc
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer H. Caplan 823 S. High

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Adam Lewis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Clara Butler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Clara Butler Lewis
(Address) 19 N. Caroline
(Edward Bryan)

15 Filed ..., 19.. Registrar

FEB 17 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Acute Endocarditis
(History of severe sorethroat)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Carlin, M. D.

2/17/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	Feb 17 30
20 UNDERTAKER Edward Bryan	ADDRESS 681 orleans St

OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 54140

REGISTERED NO. **E 54140**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 N. Arlington St. H-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kenneth Kelley

(a) RESIDENCE NO. 918 N. Arlington St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/14/28

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leon Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Bessie Fields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Leon Kelley

(Address) 918 N. Arlington St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/15/30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28 19 30 to Feb. 15 19 30

that I last saw him alive on Feb. 10 19 30

and that death occurred, on the date stated above, at 11:10 a. m.

The CAUSE OF DEATH* was as follows:

Auto Toxemia

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John H. Johnson M. D.

19 (Address) 1042 N. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2/17 19 30

20 UNDERTAKER Samuel I. Hemsley

ADDRESS 1701 Pitcher

FEB 17 1930 P. M.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54141

CERTIFICATE OF DEATH

74-001

REGISTERED NO. E 54141

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Chapple St. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Joseph Shanta.

(a) RESIDENCE NO. 517 N. Chapple St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1858.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72.		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer) Retired.

(c) Name of employer

9 BIRTHPLACE (city or town) Czecho-Slovakia
(State or country)

PARENTS

10 NAME OF FATHER Joseph Shanta

11 BIRTHPLACE OF FATHER (city or town) Czecho-Slovakia
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not-Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Joseph Shanta
(Address) 517 N. Chapple St.

15 Filed 1 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930 to Feb 16, 1930

that I last saw h alive on Feb 16. 1930

and that death occurred, on the date stated above, at 9 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Rypacek M. D.

(Address) 804 N. Chapple

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 2/19. 1930

20 UNDERTAKER August Pasch

ADDRESS 240 Cathedral St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54142 | 31 E 54142

1—PLACE OF DEATH Baltimore City Hospitals (Tbc.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-4 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Wilkuszewski

(a) RESIDENCE NO. 331 S. Caroline st. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Vincent Wiliuzewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Eleonora Kocent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records
(Address)

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 15, 19 29, to Feb. 15, 19 30, that I last saw him alive on Feb. 15, 19 30 and that death occurred, on the date stated above, at 6.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jas Stuart, M. D.

2-15, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus | DATE OF BURIAL Feb 18 1930

20 UNDERTAKER A. W. Ozazewski 1930 | ADDRESS Eastern Ave

Important: Use typewriter or pen and ink.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 54143

1—PLACE OF DEATH

REGISTERED NO. 90-71

CITY OF BALTIMORE: (No. 407 Louden Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane E. Carr

(a) RESIDENCE NO. 407 Louden Ave. ST., WARD

(Usual place of abode) life (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March --, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country)

14 Informant Warren N. Arnold

(Address) 615 Munsey Bldg.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15-30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to Feb. 15, 1930, that I last saw h[illegible] alive on Feb. 14, 1930 and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary hemorrhage

(duration) yrs. mos. Sudden, ds.

CONTRIBUTORY (Secondary) Chronic pulmonary tuberculosis

(duration) Years yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Wm Cumming Hood, M. D.

2/17, 1930 (Address) 626 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb. 17, 1930

20 UNDERTAKER John O. Mitchell & Sons, 1900 Eutaw Pl.

ADDRESS

Mahlon B. Mitchell

C. HAMPTON MYERS, M. D.

FEB 17 1930

Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54144

CERTIFICATE OF DEATH

4+

E 54144

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Eypress ST. 25-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Millard T. Birch

(a) RESIDENCE NO. 1616 Eypress ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriett M. Birch

6 DATE OF BIRTH (month, day, and year) Oct. 6th 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman at do

(b) General nature of industry, business, or establishment in which employed (or employer) Swift Fertilizer Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Penna.
(State or country)

PARENTS

10 NAME OF FATHER Levy Birch

11 BIRTHPLACE OF FATHER (city or town) Penna
(State or country)

12 MAIDEN NAME OF MOTHER Elij Olmes

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Harriett M. Birch

(Address) 1616 Eypress St.

15 Filed MAR 17 1930 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14/30

17 I HEREBY CERTIFY That I attended deceased from Nov 4, 1929, to Feb. 14, 1930

that I last saw him alive on 2.14.30, 19

and that death occurred, on the date stated above, at 8 45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Hepatica

I Dont Know (duration) yrs.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

2.15, 1930 (Address) 107 East west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Feb. 18 1930

20 UNDERTAKER D. Lilly + Son Inc

ADDRESS 4038 Wolfe st

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54145

REGISTERED NO. 129 E 54145

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2136 Frederick Ave (WARD) 20-69

2-FULL NAME Wallace B. Shrote

(a) RESIDENCE NO. 2136 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 6-1888

7 AGE: Years 42; Months —; Days 8; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): Yellow Cab

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: George Shrote

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Laura

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. Mary R. Watts

(Address) 2136 Frederick Ave.

15 Filed 19 Registrar

HAROLD JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/14 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 26, 1930, to Feb 12, 1930, that I last saw him alive on Feb 12, 1930 and that death occurred, on the date stated above, at 7.15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

Chronic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) Stuart Denning, M. D.

2/15, 1930 Address) 2000 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feb. 18 1930

20 UNDERTAKER: George L. Schmidt — ADDRESS: 3101 Fulk. Ave

TION is very important See instructions on back of certificate

FEB 21 1930

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54146 | 129 | E 54146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 54146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 420 S. Furrow St., 30-69 (WARD)

2-FULL NAME Henry L. Kuester

(a) RESIDENCE NO. 420 S. Furrow ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Kuester.

6 DATE OF BIRTH (month, day, and year) Apr 7, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry A. Kuester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Barbara Bild

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Matilda Kuester (Address) 420 S. Furrow St.

15 Filed FEB 17 1930 H. HAMPTON [illegible], M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930. to Feb. 14 1930. that I last saw h[illegible] alive on Feb. 14 1930, and that death occurred, on the date stated above, at 10 15 m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) George E. Shannon, M. D.

(Address) 700 N. Fallor Ave.

Feb 15, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Feb 18 1930

20 UNDERTAKER George L. Schmidt — ADDRESS 2101 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54147

100-001 V

E 54147

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 Carey St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jasan Higgins

(a) RESIDENCE NO. 1111 N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 2 dys. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23 1929

7 AGE	Years	Months	Days
		7	21

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Jay Higgins

11 BIRTHPLACE OF FATHER (City or town)

(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Emma Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) South Carolina

14 Informant Father

(Address) 1111 N. Carey St

15 Filed ... 19.. Registrar

C. HA... Deputy

B 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-14-1930

17 I HEREBY CERTIFY, That I attended deceased from 2-10-, 1930, to 2-14-, 1930, that I last saw him alive on 2-14-, 1930, and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 11 da.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jan H Blaumdell M. D.

2/14/1930 (Address) 1629 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Lorraine — Date of Burial 2/18 1930

20 UNDERTAKER Lemuel W. Chase & Sons — ADDRESS 1400 Mosher

OF DEATH in plain terms, so that it may be properly classified. Each statement of fact is very important. See instructions on back of certificates.

E 54148 — PLACE OF DEATH

CERTIFICATE OF DEATH

× 101-001

E 541[illegible]

REGISTERED NO. [illegible]

CITY OF BALTIMORE: (No. University Hospital ST. H-30 WARD)

(If death occurr[illegible] a hospital or in[illegible] tion, give its N[illegible] instead of stree[illegible] number.)

2—FULL NAME Robert A. Brown

(a) RESIDENCE NO. Brookville Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. m[illegible]

(If non-resident give city or town and

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 (Single, Married, Widowed, or Divorced) (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harriet Brown

6 DATE OF BIRTH (month, day, and year): Unknown 1866

7 AGE — Years: 63 — Months: 4 — Days: — — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Robert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Alexander Johnson

12 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Robert Brown

(Address) Brookville Md

15 FILED FEB 17 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February

17 I HEREBY CERTIFY, That I attended de[illegible]

Feb. 13, 1930, to Feb 16

that I last saw him alive on Feb 16

and that death occurred, on the date stated above, at 6 [illegible]

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

left upper lobe

(duration) yrs. mos. 4[illegible]

CONTRIBUTORY (Secondary)

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Samuel T. Stokes, M.

, 19 (Address) Gunning Hosp.

*State the Disease Causing Death, or in deaths from Violent Cause state (1) Means and Nature of Injury, and (2) whether Accident Suicide or Homicidal. (See reverse side for additional space.)

PLA[illegible] MOVAL [illegible] Mt. Carmel Cem

DATE OF BURI[illegible] Feb. 20 19[illegible]

20 UNDERTAKER Easton Bro[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

MARGIN RESERVED FOR [illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54149

CERTIFICATE OF DEATH

29

E 54149

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2427 N. Poppleton St., 16-76

2-FULL NAME Sidney Williams

(a) RESIDENCE NO. 2427 N. Poppleton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 865

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Ida Scott
(Address) 947 Pierce St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feary M. D.

2/16, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL Feb. 17 1930

20 UNDERTAKER J. G. Locke

ADDRESS 1302 Jeffer

OF DEATH in plain terms, so that it may be properly classified. Erase unnecessary words. Make answers complete and important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54150

CERTIFICATE OF DEATH

90

E 54150

REGISTERED NO. 28-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE, (No.) 4418 (ST.) Belview Ave (WARD)

2—FULL NAME Elizabeth Molz

(a) RESIDENCE NO. (Usual place of abode) 4418 Belview Ave ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank X. Molz.

6 DATE OF BIRTH (month, day, and year): Sept. 20-1860

7 AGE: Years 69 | Months 4 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Geo. M. Schneidohl

(Address) 4418 Belview Ave.

15 Filed: 1-7-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 15-1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to Feb 15, 1930,

that I last saw her alive on Feb 15-1930, 19

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) X yrs. X mos. 5 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 3 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Edw Talbott, M. D.

2/17, 1930 (Address) 135 S. W. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb. 18-1930.

20 UNDERTAKER: Horace F. Burger — ADDRESS: 3631 Falls Road.

Spec.—1-10-21—M&T—1500 Blks.

E 54151 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54151

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 261 E. Hamburg (St.) 24-33 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Lee.

(a) RESIDENCE NO. 261 E Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lee

6 DATE OF BIRTH (month, day, and year) Jan 2-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	82	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 06

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Ship Repair

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Oscar Strickel (Address) 261 E Hamburg.

15 Filed FEB 17 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 17, 1929, to Feb 14, 1930, that I last saw him alive on Feb 14, 1930, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. L. L. Campbell M. D.

Feb 14, 1930 (Address) 1644 Harlem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Feb 16 1930
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St.

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Cor.—10-10-29—A Co.—100 Bks.

E 54152

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-01 E 54152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 115 Hammerbacher Court. St. 23-31 Ward)

2-FULL NAME William Gilmore.(C)

(a) RESIDENCE NO. 115 Hammerbacher Court. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Do not know.

6 DATE OF BIRTH (month, day, and year) March 6, 1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	86	11	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Georgia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Maggie Harris.(C)
(Address) 115 Hammerbacher Court.

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 14, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? inquiry

(Signed) Otto Fernhandt M. D.

2/17, 1930 (Address) 1017 N. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Feb 18 1930

20 UNDERTAKER S. E. Bromo & Son

ADDRESS Madison

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B 1630 C. THAMPSON JONES, M.D.

DHH

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54153

CERTIFICATE OF DEATH

185 E 54153

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 23-31 Ward)

2-FULL NAME Thomas Lester

(a) RESIDENCE NO. 127 Hamburgers Court Ward (Winters St.)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Widower

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Martha Stewart
(Address) 123 W. Montgomery St

15 Filed C. HAMPSON JONES, M. D.
8 17 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Peritonitis due to perforation of ileum. Accidental Death. Fell against latch on boat

(duration) ..yrs. ..mos. 5 da.

CONTRIBUTORY
(Secondary)

(duration) ..yrs. ..mos. ..da.

18 Where was disease contracted if not at place of death? American Sugar Ref.
Did an operation precede death? Yes Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Eugene Feltes, M. D.
2/17, 1930 (Address) 729 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion et — DATE OF BURIAL Feb 18 1930

20 UNDERTAKER S. A. Brown & Son — ADDRESS 108 N. Mount

OF DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 54154 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54154

CERTIFICATE OF DEATH.

REGISTERED NO. 9-46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L. Swann

(a) RESIDENCE NO. 1724 Carswell St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie L. Swann

6 DATE OF BIRTH (month, day, and year) Jan 24 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) U. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A A Co Md

PARENTS

10 NAME OF FATHER Thomas J. Swann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A A Co Md

14 Informant Mamie L. Swann

(Address) 1724 Carswell St.

15 Filed 1 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1930 to Feb 15 1930

that I last saw him alive on Feb 15 1930

and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem DATE OF BURIAL Feb 18 1930

20 UNDERTAKER Mrs Mrs. John W. Taupel & Son ADDRESS 801 N. Fay St

CAUSE OF DEATH must be given. If unknown, state TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bla.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47 ✓

E 54155

CERTIFICATE OF DEATH

E 54155

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Penrose St. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Blanche M. Mc. Curdy.

(a) RESIDENCE NO. 1917 Penrose Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar A. Mc. Curdy

6 DATE OF BIRTH (month, day, and year) Mar 20. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Joshua T. Whittle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Schell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edward K. Macke

(Address) 1917 Penrose ave

15 Filed ....., 19.... Registrar

C. HAMPSON JONES, M. D.

JUL 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16. 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/31/30, 19...., to 2/16/30, 19...., that I last saw h.. alive on 2/16/30 19.... and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rt. Breast

5 months

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov 5 1929

Was there an autopsy? by / Johns Hopkins Hospital

What test confirmed diagnosis?

(Signed) Bernard J. Fenn, M. D.

2/17. 1930 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL Feb. 19 1930

20 UNDERTAKER Wm. Mus. J. H. Teufel & Son — ADDRESS 501 W. Fayette

Important: See instructions on reverse side.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54136 ✓ E 54136

CERTIFICATE OF DEATH.

REGISTERED NO. C 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3807 Bonner Rd St. 15-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Miss Alice G. Mallalieu

(Residence in Baltimore: No. 3807 Bonner Rd St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
F	W	S.

6-DATE OF BIRTH, April 7, 1874
(Month) (Day) (Year)

7-AGE, 55 yrs. 10 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer). Teacher

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER. Wm H Mallalieu

11-BIRTHPLACE OF FATHER (State or Country). England.

12-MAIDEN NAME OF MOTHER Eleanor Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Mong

(Address) 3807 Bonner Rd

15- Feb 17 1930 C. HAMPSON JONES, M. D. 1931 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, February 16, 1930
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1928, to Feb 16 1930, that I saw her alive on Feb 16 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma left breast

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY, (Secondary) Mural Carcinomatosis

(Duration) 1 yrs. mos. ds.

(Signed) Howard S. Garrison M. D.

Feb 16, 1930. (Address) 2411 Garrison Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cemetery Hanover and Pipe Md — DATE OF BURIAL, Feb 18 1930.

20-UNDERTAKER Wm Rowlens — ADDRESS 2238 N Smith

1 important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54152

CERTIFICATE OF DEATH

74-001

E 54157

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apts ST., 23-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane Newburgh

(a) RESIDENCE NO. Esplanade Apts. 1C WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

(a) If married, widowed, or divorced HUSBAND of (or) WIFE Leo Jos. Newburgh

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York, N. Y.

PARENTS

10 NAME OF FATHER Bernard Behrend

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Rosenthal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. A. Glauser

(Address) The Esplanade

15 Filed 1 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to Feb 16, 1930, that I last saw h[illegible] alive on Feb 15, 1930 and that death occurred, on the date stated above, at 12 10 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Cerebral Hemorrhage

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Emma F. Wagner, M. D.

2/17, 1930 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shek Shalom Cem.

DATE OF BURIAL 2/18/1930

20 UNDERTAKER Harid Sondheim

ADDRESS 1518 W. Mt. Royal Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54158

CERTIFICATE OF DEATH

111-001

E 54158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) W. Balto Gen Hosp (St.) 28-63 (Ward)

2-FULL NAME Albert M. Barrick

(a) RESIDENCE NO. 4407 Belview Ave (St.) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed or divorced (or) WIFE of Albert Barrick

6 DATE OF BIRTH (month, day and year) Sept 13-1875

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	54	6	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electric Worker
(b) General nature of industry, business, or establishment in which employed (or employer) B&O RR Co
(c) Name of employer

9 BIRTHPLACE (city or town) Frederick
(State or country) Md

PARENTS

10 NAME OF FATHER John Barrick

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Harriet Beck

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Addie M Barrick
(Address) 4407 Belview

15 Filed ..., 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 15 a 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) Inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Gastric Ulcer

(duration) 5 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of Feb 15

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Burk, M. D.

Feb 15 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Feb 18 1930

20 UNDERTAKER: Putnam & Poe

ADDRESS: 1723 W Lafayette Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is important. See instructions on back of certificate.

3 1 7 1930

Cor.—10-10-29—A Co.—100 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-801 ✓ E 54159

CERTIFICATE OF DEATH

E 54159

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 936-W. 30th St. 17-51 Ward)

2-FULL NAME Gertrude M. Wilhelm

(a) RESIDENCE NO. 936 W. 30th St. (Usual place of abode) Cele St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	W	married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Ernest Wilhelm

6 DATE OF BIRTH (month, day, and year) April 30 - 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	32	9	17 16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 637
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John O'Brien

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Delia Geary

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs H. R Stambaugh
(Address) 936 W. 30th Street

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

1 7 1930 by Roth

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 6 Days yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No What confirmed diagnosis? Med History

(Signed) J. C. Glades, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 2/18/30 19

20 UNDERTAKER Brown & Son Bolgerson

ADDRESS 1132

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54160

CERTIFICATE OF DEATH

100-001

E 54160

1—PLACE OF DEATH

REGISTERED NO. 15

CITY OF BALTIMORE: (No. Maryland Penitentiary Hosp. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Selmman McCullough

(a) RESIDENCE NO. 717 N. American St. ST., Philadelphia Pa. RD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. - mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colred	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) March 12, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, professinn nr particular kind nf work Bellboy

(b) General nature of industry, business, or establishment in which employed (or emplnyer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Jesse J. McCullough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia

12 MAIDEN NAME OF MOTHER Mattie Gamble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Philadelphia

14 Informant Mattie Gamble

(Address) 948 N. New Market St. Phila Pa

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1930, to Feb. 14, 1930, that I last saw him alive on Feb. 14 1930 and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autnpsy? No

What test confirmed diagnosis? Examination

(Signed) Chas Wm Edwards, M. D.

, 19 (Address) 2746 Alameda Blvd

*State the Disease Causing Death, nr in deaths from Vinient Causes, state (1) Means and Nature of Injury, and (2) whether Aecidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF HURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenville South Carolina	Feb 8 1930

20 UNDERTAKER Chas S. Black ADDRESS 142 W Northam

important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54161

CERTIFICATE OF DEATH.

99-01 E 54161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 517 E 22nd St St., 9-46 Ward)

2-FULL NAME Elizabeth Caroline Meyers

(a) RESIDENCE NO. 517 E 22nd St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph N Meyers

6 DATE OF BIRTH (month, day, and year): 6/8/1850

7 AGE: Years 79 Months 9 Days 17 IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Germany

PARENTS

10 NAME OF FATHER Geo Bakenhof

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Holland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant: Elizabeth Haugh

(Address) 517 E 22nd St.

15 Filed ..., 19... C. HUMPSON JONES, M. D. Registrar

2/17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 15th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 4th, 1930, to Feby 15th, 1930,

that I last saw h[illegible] alive on Feby 15th, 1930,

and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. A. J. Van Ness, M. D.

2/17, 1930 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial: 2/18 1930

20 UNDERTAKER: A. J. Fahey & Sons — ADDRESS: 1318 Light

IF DEATH is plainly caused by violence, or has occurred suddenly, it is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54162

CERTIFICATE OF DEATH

E 54162

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Lenox Memorial Hospital

CITY OF BALTIMORE: (No. 1000 Eaton Ave ST. 4-25 WARD)

2-FULL NAME Mary Pennant Peyrand

(a) RESIDENCE NO. 1112 Clay ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
79	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Catholic Charities
(Address) 415 Cathedral St

15 [illegible] C. HAMPSON JONES, M. D.
19 [illegible] ACH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 14 1930

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1928, to Feb. 14, 1930, that I last saw her alive on Feb. 14, 1930 and that death occurred, on the date stated above, at 10-10 a m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) George Brenner, M. D.
, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. G.G. | DATE OF BURIAL Feb 18 30.

20 UNDERTAKER John J. Fahey & Sons | ADDRESS 1318 Light St

TION is very important See instructions on back of certificate.

1 71930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54163

CERTIFICATE OF DEATH.

12 1/

E 54163

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) W. Balto. Gen. Hosp. (Ward) 20-69

2-FULL NAME Mrs Mary Hook

(a) RESIDENCE NO. 2 Willard St (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ (or) WIFE of Charles Hook

6 DATE OF BIRTH (month, day, and year) 10/19/1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas. Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry Summers

(Address) 2 Willard St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16/1930

17 I HEREBY CERTIFY, That I attended deceased from 2/14/1930, to 2/16/1930, that I last saw her alive on 2/16/1930 and that death occurred, on the date stated above, at 8.30 P m

The CAUSE OF DEATH* was as follows:

Emphysema of gall bladder

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 2/14/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) J. W. Cobb M. D.

2/19/1930 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 2/19/1930

20 UNDERTAKER Wm Cook

ADDRESS 1219 E Pratt St

See instructions on back of certificate. TION is very important

Spec.—1-10-21—MAT—1500 Blks.

E 54164 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54164

CERTIFICATE OF DEATH.

49

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (WARD) 16

2-FULL NAME Arthur Steer

(a) RESIDENCE NO. 2334 E North Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	45	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Chas. E. Steer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Rosella Toms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Miss Florence Steer

(Address) 1525 Broadway

15 Filed ..... 19 ..... Registrar

FEB 18 1930 BALTIMORE, MD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17-30

17 I HEREBY CERTIFY, That I attended deceased from 2-4 .19 30. to 2-17 .19 30.

that I last saw him alive on 2-17 .19 30.

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung - left

? (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Stupto cordis veridans endocarditis (duration) yrs. mos. 15 da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Robert Calde M. D.

.19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 2/19/1930

20 UNDERTAKER Wm. Cook

ADDRESS 127 St Paul St

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—1-30—M. & T.—250 Blks.

E 54165

E 54165 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 10-14 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Heinlein

(a) RESIDENCE NO. 1100 McKean Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie E.

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
(44)	43	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Christian Heinlein

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Susie Derr

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Records of

(Address) Balto. City Hospital

15 Filed FEB 18 1930 Registrar C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-15-30

17 I HEREBY CERTIFY, That I attended deceased from 2-13-30, 19..., to 2-15-30, 19...,

that I last saw h... alive on 2-15-30, 19...,

and that death occurred, on the date stated above, at 11:20 A.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Nephritis, Chronic Parenc

(duration) 3? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Culture, X-ray, Lab.

(Signed) Marvin Thorner Gray M. D.

2-17, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetary

DATE OF BURIAL 2/19/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See ...

Spec.—1-30—M. & T.—250 Bks.

Dr Seabury 636 E Fort Ave

E 54166 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 54166

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3403 Clifton Ave St. 25-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Harris

(a) RESIDENCE NO. 1304 Gloster Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8-1881 Baltimore

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Harris

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Sarah Townsend

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Edward Thawney

(Address) 1304 Gloster Ave

HAMILTON JONES, M. D.

FEB 16 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1930, to Feb. 16, 1930, that I last saw her alive on Feb. 14, 1930, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 1 yrs. mos da.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? repeal

(Signed) Wm. L. Seabury, M. D.

2/17, 1930 (Address) 636 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 2/18/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-10-21—M&T—1500 Bks.

Era Oliver

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54167 / VE 54167

CERTIFICATE OF DEATH.

E 54167

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N. Eaton St. 10-24 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Era Oliver

(a) RESIDENCE NO. 1023 N. Eaton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: 61 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

60

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Thos Marlow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Betty —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Ora Tolbert
(Address): 1023 Eaton St

15 Filed ..... 19 ..... HARRISON JONES, M. D. Registrar

FEB 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20

17 I HEREBY CERTIFY, That I attended deceased from September 29, to Feb 20, 1930

that I last saw him alive on Feb 17, 1930

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Eye

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Infected Leg

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Gill, M. D.

19 (Address) 822 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 2/20 1930

20 UNDERTAKER: Jesse H. Redden

ADDRESS 436 N. Biddle

CAUSE OF DEATH must be plainly written. See instructions on back of certificates. TION is very important.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 54168

REGISTERED NO. 10-14

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie Meyers

(a) RESIDENCE NO. Preston + Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Meyers

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Augusta " "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston + Valley Sts

15 Filed FEB 16 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 3 1930, to Feb 15, 1930, that I last saw h alive on Feb 14, 1930 and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernstein, M. D.

2/17, 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Feb 18 1930

20 UNDERTAKER Rita Friedfeld — ADDRESS 914 Fremont Ave

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54169

CERTIFICATE OF DEATH.

E 54169

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1503 N. Fulton Av (ST.) 15-21 (WARD)

2-FULL NAME J. Henry Gerstmeyer

(a) RESIDENCE. NO. 1903 N. Fulton Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Louis Gerstmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Sophia Beilstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mrs Anna Lordeman 1923 N. Fulton Ave.

15 Filed FEB 18 1930

16 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb-9th 1930. to Feb-16th 1930.

that I last saw h alive on Feb-16th 1930.

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage - hemiplegia

Respiratory & Cardiac insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Arteriosclerosis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex.

(Signed) Jno Jones, M. D.

19 (Address) 2802 Rosleyn Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Feb 19th 1930

20 UNDERTAKER: B Schlosman & Son

ADDRESS: 1039 Gannon Av

CAUSE OF DEATH to plainly written. See instructions on back of certificates. TION is very important.

B 18 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54170 ✓ 38 E 54170

E 54170

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Balto Md ST. 13-59 WARD

2—FULL NAME Lucretia Gaskins

(a) RESIDENCE NO. 2446 Francis St ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Gaskins

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records Balto City Hosp (Address)

15 Filed FEB 18 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16-30

17 I HEREBY CERTIFY, That I attended deceased from 10-29-, 1929, to 2-16-, 1930, that I last saw her alive on 2-16-, 1930, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

I Thyroid Toxicosis

Psychosis - Hyperthyroidism (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of 2/15/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Mary E. Brown M. D.

19 (Address) 1715 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL Feb 19 1930

ADDRESS 916

20 UNDERTAKER Dean Eads

Co

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54171

E 54171

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Calhoun ST., 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mildred Modena Commander

(a) RESIDENCE NO. 1112 Calhoun ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Commander

6 DATE OF BIRTH (month, day, and year) Dec 7. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. at

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer Standard Oil Co. Orange Co.

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Lato Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Amy Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Jessie Lewis

(Address) 1112 Calhoun

15 Filed FEB 16 1930 C. FAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1928, to Feb 15, 1930, that I last saw h~~e~~ alive on February 12, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

(duration) 2 yrs. 1 mos. 16 da.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 2 yrs. + mos. da.

18 Where was disease contracted if not at place of death? ~~-~~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) Wm. N. Wrigley, M. D.

2/16, 1930 (Address) 1209 Preston Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Feb 19 1930

20 UNDERTAKER Daniel Conlon

ADDRESS 916 Pa Ave

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54172

E 54172

CERTIFICATE OF DEATH.

REGISTERED NO. 1001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 703½ N Saratoga ST., 4 16 WARD)

2-FULL NAME Edw Poulson

(a) RESIDENCE NO. 703½ N Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Poulson

6 DATE OF BIRTH (month, day, and year) 7 Mar 1885 68.86

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of Industry, business, or establishment in which employed (or employer) 07

(c) Name of employer M & M Transportation

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Va

PARENTS

10 NAME OF FATHER Louis Poulson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eastern Shore Va

12 MAIDEN NAME OF MOTHER ~~unknown~~ Fannie Fowlers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Va

14 Informant Nellie Poulson

(Address) 703½ Saratoga

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/17 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/10 1930, to 2/17 1930, that I last saw him alive on 2/16 1930, and that death occurred, on the date stated above, at 8 am —

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Gustav Rothman, M. D.

, 19 (Address) 856 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2-18 1930

20 UNDERTAKER Howard Easton

ADDRESS 916 Ca ave.

Cor.—10-10-29—A Co.—100 Bks.

Cralley. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 54173

CERTIFICATE OF DEATH

E 54173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. (St.) 27-54 (Ward)

2-FULL NAME Earl Cralley

(a) RESIDENCE NO. 1925 Kelly Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 12-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		5	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER John Cralley

11 BIRTHPLACE OF FATHER (city or town) Unk
(State or country)

12 MAIDEN NAME OF MOTHER Florence Price

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Florence Cralley
(Address) 1925 Kelly Av

15 Filed ..... 19.. C. HARRISON KELLY, M. D. Registrar

FEB 18 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. Blank M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Feb 16 1930
20 UNDERTAKER	ADDRESS
Virginia A Brohawn	1403 N. Carey

OF DEATH in plain terms, so that it may be properly classified. Exact information is important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54174

CERTIFICATE OF DEATH

E 54174

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 N. Carrollton Ave St. 16-26 WARD)

REGISTERED NO. 1001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosie Hall

(a) RESIDENCE NO. 620 Carrollton Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hall

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harrison Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Helen Hall

(Address) 620 Carrollton

15 Filed FEB 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 7, 1930, to Feby 15, 1930, that I last saw h[er] alive on Feby 15, 1930 and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) W. S. Smith, M. D.

Feby 17, 1930 (Address) 129 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cem

DATE OF BURIAL 2-19 1930

20 UNDERTAKER Byron W. Wright

ADDRESS 1218 Mc Elderry St

Cor.—10-10-29—A Co.—100 Bks.

E 54175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-801 E 54175

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Gen'l Hosp St 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt Bowling.

(a) RESIDENCE NO 1242 St Mathews St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora -

6 DATE OF BIRTH (month, day and year): 1893

7 AGE: 37 Years 36 | Months | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country): "

PARENTS

10 NAME OF FATHER: Tyler Bowling

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country): "

12 MAIDEN NAME OF MOTHER: Pauline Wasten

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country): "

14 Informant: Tyler Bowling
(Address): [illegible]

15 Filed ... 19... Registrar C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Feb 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death by ... (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) ... M. D.
Feb 11 1930 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	Feb 11 1930
20 UNDERTAKER	ADDRESS
Robert T. Williams	1518 W. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

B 1 8 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 54176

HEALTH DEPARTMENT—CITY OF BALTIMORE

43 ✓ E 54176

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 E North Ave ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Steiner

(a) RESIDENCE NO. 2012 E. North ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. — mos. 3 ds. How long in U. S., if foreign birth? 23 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Ella. E. Steiner

6 DATE OF BIRTH (month, day, and year) Apr. 7 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter for 070

(b) General nature of industry, business, or establishment in which employed (or employer) Miller Bros.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Steiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Ella. E Steiner

(Address) 2012 E. North ave

15 Filed FEB 18 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17 1930

17 I HEREBY CERTIFY, That I attended deceased from November 15, 1929 to February 17, 1930.

that I last saw him alive on February 16, 1930

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary) Metastasis to Pleura

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Cumberland, M. D.

2/17, 1930 (Address) 2075 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer cemetery

DATE OF BURIAL Feb 19 1930

20 UNDERTAKER Feney Hoed, Sons, Inc.

ADDRESS 1301 E Eager St

Important: See instructions on reverse side.

Spec.—1-10-21—M&T—1500 Bks.

E 54177

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54177

CERTIFICATE OF DEATH.

100-001

72-33

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 E. Churchill St. (St.) (Ward)

2-FULL NAME Anna A. King.

(a) RESIDENCE NO. 111 Churchill St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: ----------

6 DATE OF BIRTH (month, day, and year): Dec, 26, 1928

7 AGE — Years: 1 Months: 1 Days: 19. If LESS than 1 day, hrs. or min.: 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Elmer W. King.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Elizabeth M. Wendel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Anna M. King. (mother)
(Address): 111 E. Churchill St.

15 Filed FEB 18 1930, 19 ..... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 15th 1930

17 I HEREBY CERTIFY, That I attended deceased from February 5th, 1930, to February 15th, 1930,

that I last saw her alive on February 15th 1930,

and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Mitral Insufficiency.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt, M. D.

12/17/1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. M. E. — DATE OF BURIAL: Feb 18 1930

20 UNDERTAKER: John F. Denny. — ADDRESS: W. Lig. at St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54178

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54178

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 9-44 Ward)

2-FULL NAME Jean Marie Acker

(a) RESIDENCE NO. 2202 Hugo Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
F.	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/4/1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	6	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country)

PARENTS

10 NAME OF FATHER Joseph A. Acker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ethel M. Metzel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Joseph Acker,
(Address) 2202 Hugo Av.

15 Filed 3 1 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Feb 15/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. Vallen, M. D.

2/17/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 2/18 1930

20 UNDERTAKER George J. Puth 1735 Harford Ave

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

2 B 54179 — 135 E 54179

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Blondheim

(a) RESIDENCE NO. 2734 E Chase ST., St — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Knoop 9/20/83

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	70	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Samuel Blondheim

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL C. THOMPSON JONES

15 Filed ..... 19 ..... By ..... Registrar

FEB 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-16-30

17 I HEREBY CERTIFY, That I attended deceased from June 11 1929 to Feb-16 1930, that I last saw him alive on Feb 16 1930 and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

Operation: Jan 22 1930 - Suprapubic Prostatectomy

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pyelonephritis. Pulmonary Edema and pleurisy (duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Jan. 22. 1930

Was there an autopsy? No.

What test confirmed diagnosis? Blood chemistry. X-ray &

(Signed) H. C. Smith, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL 2/19/30

20 UNDERTAKER George Ruth Son — ADDRESS 1935 Harford Av

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 54180

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54180

CERTIFICATE OF DEATH.

REGISTERED NO. 101-001

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves ST. 25-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Wellon

(a) RESIDENCE NO. St Agnes Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Cenlinan

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Bennett Neal Wellon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Sappington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs. B. N. Wellon Chestertown Md (Kent Co)

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-13 1930 to 2-17 1930.

that I last saw him alive on 2-17 1930,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen M. D.

, 19 (Address) St Agnes Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestertown Kent Co. Md.

DATE OF BURIAL 2/20 1930

20 UNDERTAKER J. F. McCauley

ADDRESS 930 E Fort

CAUSE OF DEATH in plain English. See instructions on back of certificates. TION is very important.

B 1 1930 H. HAMILTON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54181

CERTIFICATE OF DEATH

101-001

E 54181

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 728 W. Fairmount Ave Ward 21a)

2-FULL NAME Beatrice Brown

(a) RESIDENCE NO. 728 W. Fairmount Ave Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 10 - 1919.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	10	4	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At school
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Matthews

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Eva Palmer (aunt)
(Address) 728 W. Fairmount Ave

15 Filed ..... 19.. C. HEMPSTONE JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

2/17. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Feb. 19 1930

20 UNDERTAKER John M. Johnson

ADDRESS 2325 Madison Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 19 1930

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 54182

CERTIFICATE OF DEATH.

E 54182

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 Riverside Ave ST., 24th WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Weedon

(a) RESIDENCE NO. 1030 Riverside Ave., 24th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna Moran.

6 DATE OF BIRTH (month, day, and year) Jan 31, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	73	0	16 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer U.S. Government, D.C.

9 BIRTHPLACE (city or town) (State or country) a. a. Co Md.

PARENTS

10 NAME OF FATHER Charles C Weedon

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Brewer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A. A. Co. Md

14 Informant Mrs Anna Weedon

(Address) 217 E Cross St

15 Filed FEB 18 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1926 to February 16, 1930, that I last saw him alive on February 15, 1930, and that death occurred, on the date stated above, at 9¼ m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. 5 mos 0 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Henry T. Buettner M. D.

FEB 16 1930 (Address) 1319 Light St, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Moran's A. A. Co. Md — DATE OF BURIAL Feb 18 1930

20 UNDERTAKER Charles L. Gleaves — ADDRESS (1501) E Fort Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓ E 54183

E 54183

CERTIFICATE OF DEATH

REGISTERED NO. 20-27

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1919 (ST.) Laureta (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pearl E. Watts

(a) RESIDENCE NO. 1919 (ST.) Laureta (WARD)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 7 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE C | 5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Delancey Watts

6 DATE OF BIRTH (month, day, and year) July 6 1895

7 AGE Years 34 | Months 7 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Horace Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mamie Dailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lena Dobson

(Address) 715 Brune St

15 Filed 1930 (Registrar) E. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 30

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1930, to July 15, 1930, that I last saw her alive on July 15, 1930, and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward E. Magruder, M. D.

July 17, 1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

(DATE OF BURIAL) July 19 1930

20 UNDERTAKER Sam H Chase Sons

ADDRESS 1400 Mosher

AUG 18 1930

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54184

CERTIFICATE OF DEATH.

129 E 54184

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 McElderry ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Richardson

(a) RESIDENCE NO. 1535 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Alice Richardson

6 DATE OF BIRTH (month, day, and year) July 4 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~1855~~	44	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City Employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Alice Richardson (Address) 1535 McElderry St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16- 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-12-, 1930, to 2-16-, 1930, that I last saw h alive on 2-15-, 1930, and that death occurred, on the date stated above, at 905 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulitis

Contributory

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Georgia, M. D.

2-17-, 1930 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery

DATE OF BURIAL Feb 20 1930

20 UNDERTAKER Robert E. Williams

ADDRESS 1515 McElderry St

TION is very important. See instructions on back of certificate.

FEB 18 1930 G. HAYWOOD JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54185 74-002 E 54185

CERTIFICATE OF DEATH

REGISTERED NO. 27-53

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 123 Hawthorne Road ST.) (WARD)

2—FULL NAME Isabella Turner Stinchcomb

(a) RESIDENCE NO. 123 Hawthorne Rd ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 89 yrs. 11 mos. 14 ds. How long in U. S., if foreign birth 89 yrs. 11 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William M. Stinchcomb

6 DATE OF BIRTH (month, day, and year) March 3 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Turner

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Brader

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Mrs. Irene Forland-Daughter

(Address) 123 Hawthorne Rd

15 Filed FEB 18 1930 16 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17-1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 1, 1930, to Feby 16, 1930, that I last saw h.. alive on Feby 16, 1930 and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral arterio sclerosis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Harry H. McCarty, M. D.

2-17-1930 (Address) 57 W. Preston st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Feb 19 1930

20 UNDERTAKER Edward Mann Co. ADDRESS Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54186 ✓ × 49 E 54186

CERTIFICATE OF DEATH

REGISTERED NO. 4

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. Md. General Hospital ST., 11-24 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Bowers Balt. Athletic Club

(a) RESIDENCE NO. 1422 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 / ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs. Daniel Bowers

6 DATE OF BIRTH (month, day, and year) 1/3/1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cigar Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Cigar
(c) Name of employer

9 BIRTHPLACE (city or town) N. Y. City
(State or country) N. Y.

PARENTS

10 NAME OF FATHER George H. Bowers
11 BIRTHPLACE OF FATHER (city or town) N. Y. City
(State or country)
12 MAIDEN NAME OF MOTHER Margaret Dot
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14 Informant Mrs Addie Doty
(Address) 740 Hancock Brooklyn N.Y.

15 Filed 2-19-30, 19 [illegible] Registrar

B 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16/30

17 I HEREBY CERTIFY, That I attended deceased from 1/22, 1930, to 2/16, 1930, that I last saw h[illegible] alive on 2/16, 1930, and that death occurred, on the date stated above, at 1 20 P. m.

The CAUSE OF DEATH* was as follows:
Carcinomatosis - primary in Lung
(duration) about yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Fracture of pubic ramus due to [illegible]
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? Yes Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.
2/16, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tarrytown New York
DATE OF BURIAL Feb 19 1930

20 UNDERTAKER George J. Smith
ADDRESS 15 32 Hollins

Spec.—2-29-28—L. F. S.—500 Blks.

E 54187

HEALTH DEPARTMENT—CITY OF BALTIMORE

135 E 54187

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. (ST.) 15-6 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nelson A. Showacre.

(a) RESIDENCE NO. 2212 Garrison Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Showacre.

6 DATE OF BIRTH (month, day, and year) 12/29/1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George W. Showacre

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14 Informant Matilda Showacre

(Address) 2212 Garrison Blvd

15 Filed ..., 19 ... Registrar

E. HUMPHREY JONES, M. D.

FEB 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1930, to Feb. 17, 1930, that I last saw him alive on Feb. 17, 1930 and that death occurred, on the date stated above, at 12:10 p. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate Gland with acute retention of urine.

(duration) yrs. mos. 2 ds. (?)

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds. (?)

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of Diagnosis 2/12/30

Was there an autopsy? No Clinical.

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2 17 Bo (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Feb 20 1930
20 UNDERTAKER George J. Smith	ADDRESS 453 Hollins

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54188 233997 CERTIFICATE OF DEATH + 84 E 54188

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ ST., 29 WARD)

2—FULL NAME Ruth Gillman

(a) RESIDENCE NO. New York City N.Y. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F | 4 COLOR OR RACE: W. | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Nov 18 1913~~

6 DATE OF BIRTH (month, day, and year): ~~Nov 20 1913~~ 3

7 AGE: 16 | Years: 16 | Months: 10 | Days: 29 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): School

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New York City

PARENTS

10 NAME OF FATHER: Bernard Gillman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Anna Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 FEB 18 1930 J. HAMPSON JONES, M.D. Registrar

BY Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 17-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930, to Feb. 17, 1930, that I last saw h.er alive on Feb 17, 1929 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Brain Tumor, Hydrocephalus (benign

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/14/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation and autopsy

(Signed) Clarence B. Gardner Jr. M.D.

2/17, 1930 (Address) Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York City N.Y.

DATE OF BURIAL: 2/18 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 Eastern Av

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54189

54189

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Stratford apt D.1

CITY OF BALTIMORE: (No.) Liberty Heights Ave & Shelton St (5-61 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas George Maire

(a) RESIDENCE NO. Stratford apt D.1 Liberty Heights Ave & Shelton ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Nora Maire

6 DATE OF BIRTH (month, day, and year): Aug 28/1862

7 AGE — Years: 67 — Months: 5 — Days: 21 — If LESS than 1 day, hrs. or ..... min.: 20

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Maire

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Gilpin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Robert W. Maire
(Address): Stratford apt D1 Liberty Hgts Shelton St

15 Filed: 1 8 1930 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16 1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to Feb. 8, 1930, that I last saw him alive on Feb 17, 1930, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
Uremia Sudden — Natural
Accidental or Industrial Injury

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) J. C. Emrich, M. D.

Feb 18 1930 (Address) 4208 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Feby 20 1930

20 UNDERTAKER: Harry R. Amacher — ADDRESS: 4204 Ridgewood Ave

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54190

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54190

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 15-68

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Cullen

(a) RESIDENCE NO. 1818 Warwick ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Cullne

6 DATE OF BIRTH (month, day, and year) 1893 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
31	36 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 029

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Cullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Cullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address)

15 2-18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19, 1929, to Feb. 17, 1930, that I last saw h. im alive on Feb. 17, 1930 and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Jas Thrush M. D.

2-17, 1930 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL Feby 20 1930

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1918 W. North ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54191 90 E 54191

CERTIFICATE OF DEATH

REGISTERED NO. 1-24

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 Woodlawn Rd. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara E. Cary

(a) RESIDENCE NO. 16 N. Read St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Cary

6 DATE OF BIRTH (month, day, and year): June 27 1854

7 AGE: Years 75 Months 7 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Maud B. Cary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Maud B. Cary

(Address) 16 N. Read St.

15 Filed: FEB 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 16 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-17, 1929, to 2-16, 1930, that I last saw her alive on 2-15, 1930 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

MYOCARDIAL INSUFFIC.

(duration) 4+ yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemy.

DATE OF BURIAL: Feb. 19 30

20 UNDERTAKER: John C. Mitchell & Sons

ADDRESS 1900 Eutaw St.

Spec.—1-13-23—M&T—500 Blks.

E 54192

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54192

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1726 n. Carey St ST. 15-21 WARD

2-FULL NAME Charles T. Stewart

(a) RESIDENCE NO. 1726 n. Carey St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary F. Stewart

6 DATE OF BIRTH (month, day, and year) 3-13-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ...min
	54	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance 071

(c) Name of employer Mutual Benefit.

9 BIRTHPLACE (city or town) St. martins

(State or country) Dutch West Indies

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town) unknown

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown

(State or country)

14 Informant Mary F. Stewart

(Address) 1726 n. Carey St.

15 Filed 3 18 1930 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17- 1930

17 I HEREBY CERTIFY, That I attended deceased from 9-6- , 1929 to 2-17- , 1930, that I last saw h[illegible]ive on 2-16- , 1930 and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart Disease

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George C. Page M. D.

, 19 (Address) 1516 n. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Evergreen Cemetery

DATE OF BURIAL 2/19 1930

20 UNDERTAKER Mrs Thos G. Bailey

ADDRESS 1425 Jefferson St

TION is very important See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E254193 ~~E233695~~ HEALTH DEPARTMENT—CITY OF BALTIMORE 145-001 E 54193

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ ST. 1-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maynell White

(a) RESIDENCE NO. 707 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harrison

6 DATE OF BIRTH (month, day, and year) July 27-1911

7 AGE	Years	Months	Days 20	If LESS than 1 day, hrs. or min.
	18	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 097

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Car

PARENTS

10 NAME OF FATHER William Bers

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Car

12 MAIDEN NAME OF MOTHER Blanche Howe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

FEB 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930, to Feb 17, 1930, that I last saw her alive on Feb 17th, 1930 and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis General - Bronchopneumonia

(duration) yrs. mos. 13 da.

CONTRIBUTORY (Secondary) Intrauterine Injection

(duration) yrs. mos. 6 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 5, 1930

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Charles M. McLane, M. D.

2/17, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Evergreen Cemetery

DATE OF BURIAL 2/20 1930

20 UNDERTAKER Mrs Lulu H. Bailey

ADDRESS 1422 Jefferson St

IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.—1-12-23—M&T—500 Bks.

E 54194

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54194

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 255 So Hilton ST. 20-20 (WARD)

2-FULL NAME Mary A. Gillen

(a) RESIDENCE NO. 255 So Hilton St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 8-1878

7 AGE 51 Years 2 Months 8 Days If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Gillen

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Miss Julia Gillen 255 S Hilton St.

15 1 8 1930 C. HAMPSON JONES, M. D., Registrar

Pat ..... Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/15 1930, to 2/16 1930, that I last saw h[illegible] alive on 2/16 1930, and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) E. Miller Hemming M. D.

2/17 1930 (Address) 707 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL Feb 19 1930

20 UNDERTAKER H. Browning & Son ADDRESS 11 N Poppy Street

Spec.—1-30—M. & F.—250 Bks.

E 54195

HEALTH DEPARTMENT—CITY OF BALTIMORE E 54195

CERTIFICATE OF DEATH.

129

REGISTERED NO. 20-28

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 214 S. Payson St. ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Ryan

(a) RESIDENCE NO. 214 S. Payson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 23, 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cloth Weaver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schloss Brothers

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Mary Miller

(Address) 214 S. Payson St.

15 FILED 2 18 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 15-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to February 15, 1930; that I last saw him alive on February 15, 1930, and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Cerebral

Arteriosclerosis Myocarditis

Other Intestinal Nephritis

(duration) Chronic yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert C. Hatch, M. D.

2/18/30 19 (Address) 2152 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Feb. 19/30

20 UNDERTAKER Harry N. Pentz & Co. 4101 Edmondson Ave.

ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54196 13 V E 54196

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. ST. 27-55 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Otie Butterworth

(a) RESIDENCE NO. 3516 Haywood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. ? How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. R. O. Butterworth

6 DATE OF BIRTH (month, day, and year) May 17, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auctioneer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Petersburg (State or country) Virginia

PARENTS

10 NAME OF FATHER G. W. Butterworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mattie Southhall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital record (Address)

15 Filed 1 8 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1930, to Feb. 18, 1930, that I last saw him alive on Feb. 18, 1930 and that death occurred, on the date stated above, at 4:40 A.m.

The CAUSE OF DEATH* was as follows:

Urinary Calculi with Acute Urinary retention

(duration) yrs. mos. 2 ds. (?)

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds. (?)

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Lab test

(Signed) [illegible] M.D.

2/18/30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dover Church Cemetary

DATE OF BURIAL 2/20/ 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

Important: Use Indelible Pencil

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54197

CERTIFICATE OF DEATH

E 54197

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1626 Linden Ave St. 14-20 Ward)

2-FULL NAME Mildred L. Bausel

(a) RESIDENCE NO. 1626 Linden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day and year): Nov 11 - 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
		3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Sidney Bausel

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Olive Smith

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Sidney Bausel
(Address): 1626 Linden Ave

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar
By ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Feb 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed disgnosis? Regnlay

(Signed) F. C. Leuk, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 2/20/1930

20 UNDERTAKER: D. Wm Cook

ADDRESS: 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Time of burial got from Undertaker 2-16-1930 at 3 P.M.

Spec.—1-30—M. & T.—250 Blks.

E 54198

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54198

CERTIFICATE OF DEATH.

90

REGISTERED NO. 27-47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 4517 Harford Ave ST. (WARD)

2-FULL NAME David Markley

(a) RESIDENCE NO. 4517 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Markley

6 DATE OF BIRTH (month, day, and year) Mar 1, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Jacob Markley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germony

12 MAIDEN NAME OF MOTHER Mary M

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germony

14 Informant Samuel Markley

(Address) 4517 Harford Ave

15 Filed ....., 19 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec-16, 1929; to Feb-17, 1930, that I last saw him alive on Feb-17, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pyelitis -

(duration) yrs. 1 mos 17 ds.

CONTRIBUTORY (Secondary) Myocarditis -

(duration) yrs. 1 mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) E. Gill Hall, M. D.

, 19 (Address) 1631 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 2/20 1930

20 UNDERTAKER Wm Cook

ADDRESS 1219 E Pond St

FILED 2/18/1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54199

CERTIFICATE OF DEATH

185 E 54199

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital 27-41 Ward)

2-FULL NAME John Edward Heikel

(a) RESIDENCE NO. 3217 Montebello Rersace Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Laura E. Heikel

6 DATE OF BIRTH (month, day, and year) Dec 31/1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	1	17 16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer Canton R.R.

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Heikel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Anna Schier

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Laura E. Heikel
(Address) 3217 Montebello Ter

15 Filed 8 18 1930 G. HAMPSON JONES M.D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 17/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Concussion-Fractured Skull. Accidently fell in pit while working om locomotive.on

Feb 14/30 (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Canton Shops

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature], M. D.

2/18/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 2/20/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Erasures or alterations make certificate important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54200

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-002

E 54200

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 11-69

CITY OF BALTIMORE: (No. 2626 St Benedict St WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carl F. Schade

(a) RESIDENCE NO. 2626 St Benedict St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 1 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed or divorced HUSBAND of (or) WIFE of: Augusta M. Schade

6 DATE OF BIRTH (month, day, and year): June 4th 1896

7 AGE: Years 34 | Months 1 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward Schade

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ida Goldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Orleans La

14 Informant: Augusta M. Schade

(Address) 2626 St Benedict St

Filed 1-8-1930, 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/16/30

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to Feb. 16, 1930,

that I last saw him alive on Feb. 16, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Ulcer of Duodenum.

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Internal Haemorrhage 2 hrs.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Xray.

(Signed) Chas. C. Conser, M. D.

2/17, 1930 (Address) 1101 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Feb 19th 1930

20 UNDERTAKER: H. A. Wagner & Sons

ADDRESS: Baltimore Md

Spec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54201

CERTIFICATE OF DEATH

129 E 54201

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2713 Fait Ave. ST. 1-3 WARD)

2—FULL NAME ANNA KORBIEN

(a) RESIDENCE NO. 2713 Fait Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Korbien

6 DATE OF BIRTH (month, day, and year) June 14, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Julius Seifert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Haussner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant (?) Irene Korbien (Daughter)
(Address) 2713 Fait Ave.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M.D.
FEB 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1930, to Feb. 16, 1930.

that I last saw her alive on Feb. 16, 1930.

and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia, Uraemic Coma.

36 Hours.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Edward McClanahan M. D.

(Address) 3508 Bank St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery.

DATE OF BURIAL Feb. 18, 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St. & Broadway.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54202

CERTIFICATE OF DEATH

74-001

E 54202

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 515 Otterbein St. 21-24 Ward)

2-FULL NAME Catherine E. Mink

(a) RESIDENCE NO. 515 Otterbein St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon A Mink

6 DATE OF BIRTH (month, day, and year) March 17-1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimor
(State or country) Md

PARENTS

10 NAME OF FATHER John Connolly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Irland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Simon A Mink
(Address) 515 Otterbein St

15 Filed 19 G. HARRISON JONES, M. D. Registrar

FEB 19 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contrarted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zollers, M. D.

2/18. 1930 (Address) 275 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 2 19 1930

20 UNDERTAKER George J Ruth — ADDRESS 1735 Hanford Ave

OF DEATH in plain terms, so that it may be properly classified. Last statement is important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 M.M. E 54203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

159-002 E 54203

REGISTERED NO. 25-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2249 Eddey St ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Dekoyer.

(a) RESIDENCE NO. 2249 Eddey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 2/15/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. and

(b) General nature of industry, business, or establishment in which employed (or employer) Infant.

(c) Name of employer 2249 Eddey St

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Charles Frederick Dekoyer

11 BIRTHPLACE OF FATHER (city or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Augustus Eadie

13 BIRTHPLACE OF MOTHER (city or town) Maryland.

(State or country)

14 Informant Mother & Father

(Address) 2249 Eddey St

15 Filed ..... 19 1368 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-18-30

17 I HEREBY CERTIFY, That I attended deceased from 2-15-30, 19.., to 2-18-, 1930, that I last saw h.. alive on 2-17-30, 19.., and that death occurred, on the date stated above, at 7:00 A.m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Lesion

Patent foramen ovale.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital.

Did an operation precede death? No Date of

Was there an autopsy? No Clinical.

What test confirmed diagnosis?

(Signed) W. Alexander Norris, M. D.

19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health

DATE OF BURIAL 19

ADDRESS FEB 18 1930

FEB 19 1930 G. HAMPSON JONES, M. D.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 54204

CERTIFICATE OF DEATH

E 54204

1—PLACE OF DEATH Provident Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division St. 14-20 WARD)

2—FULL NAME Infant Reid

(a) RESIDENCE NO. Provident Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-17-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant - Col

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Alfonso Rollins

11 BIRTHPLACE OF FATHER (city or town) Georgia (State or country)

12 MAIDEN NAME OF MOTHER Estelle Reid

13 BIRTHPLACE OF MOTHER (city or town) Georgia (State or country)

Informant Estelle Reid

(Address)

Filed 2-19-30 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17-30

17 I HEREBY CERTIFY, That I attended deceased from 2-17-30, 19..., to 2-17-30, 19..., that I last saw alive on 2-17-30 19... and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Premature
Macerated Fetus
Prob. Uterus

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Bunting, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: FEB 18 1930 19

UNDERTAKER

ADDRESS

Commissioner Health.

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

183 ✓

E 54205

CERTIFICATE OF DEATH

E 54205

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 27-44 Ward)

2-FULL NAME Martin Nugent

(a) RESIDENCE NO. 4900 Morrello Road St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna G. Nugent

6 DATE OF BIRTH (month, day, and year) May 1/1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	9	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sea Captain
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) New Foundland

PARENTS

10 NAME OF FATHER Emory Nugent

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New Foundland

12 MAIDEN NAME OF MOTHER Elizabeth Kennedy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New Foundland

14 Informant Anna G. Nugent
(Address) 4900 Morrello Road

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 15/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shot gun wound-upper left abdomen

Accidently while cleaning gun,

(Feb 15/30)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? in his home

Did an operation precede death? yes Date of Feb 15/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

2/18/30 (Address) 508 E, North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Feby 20 1930

20 UNDERTAKER [signature] ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Last address must be given. Name of deceased must be given in full, and if a married woman, the name of her husband must be given in full. Occupation must be given in all cases. Cause of death must be certified to by a physician, if there was one in attendance, and the coroner must be notified in all cases of violent death. Physicians are required to report cases of death occurring without medical attendance. Information should be given by some person who knows the facts. All questions must be answered if possible. Do not state "Unknown" if any reasonable effort will obtain the information. Write plainly with pen and ink. Use no abbreviations. The certificate must be complete and correct before a permit for burial will be issued. See instructions on back of certificate.

Spec.—1-30—M. & T.—950 Bks.

Dr Franck 1907 Eutaw Place

E 54206 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54206

CERTIFICATE OF DEATH.

91

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2409 Maryland Ave ST. 17-51 (WARD)

2-FULL NAME Virginia Frances Merrill

(a) RESIDENCE NO. 2409 Maryland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Merrill

6 DATE OF BIRTH (month, day, and year) June 9 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Thomas Lombden

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Catherine Lombden

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs R. Bishop (Address) 2409 Maryland Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17. 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 1929 to Feb 17 1930, that I last saw h.. alive on Feb 17 1930, and that death occurred, on the date stated above, at 9:45 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

2/19 1930 (Signed) [illegible] M. D. (Address) 1709 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn City, Md DATE OF BURIAL 2/20 1930

20 UNDERTAKER W. Cook ADDRESS 1217 E Baltimore St

Spec.—2-20-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54207

CERTIFICATE OF DEATH

90

E 54207

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 105 Sorrento Ave. ST., 28-7 WARD)

2—FULL NAME John F. Birkmeyer, Sr.

(a) RESIDENCE NO. 105 Sorrento Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Birkmeyer

6 DATE OF BIRTH (month, day, and year) July 31, 1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93	6	16 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Candy Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Wurtemburg
(State or country) Germany

PARENTS

10 NAME OF FATHER Louis Birkmeyer

11 BIRTHPLACE OF FATHER (city or town) Wurtemburg
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Wessel

13 BIRTHPLACE OF MOTHER (city or town) Wurtemburg
(State or country) Germany

14 Informant Mr. Charles C. Hoffman
(Address) 1935 W. Fayette St.

15 Filed FEB 19 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1930, to Feb. 16, 1930, that I last saw h im alive on Feb. 16, 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema of the Lungs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eugene Zetter, M. D.

2/18 1930 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Feb. 19 1930

20 UNDERTAKER Robt. H. Cook

ADDRESS 1003 West Baltimore St

E 54208

STATE OF MARYLAND
CERTIFICATE OF DEATH

74-001 ✓ E 54208

Registration Dist. No. .....

1 PLACE OF DEATH
County Baltimore City
2315 Chelsea Terrace
Village or City ..... (No. 15-61 St.: ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Mrs Lavina A. Long 50 yrs.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F
4 COLOR OR RACE: W
5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: Sept 14, 1852 (Month) (Day) (Year)

7 AGE: 77 yrs. 5 mos. 4 ds. | If LESS than 1 day ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country): Carroll Co.

PARENTS

10 NAME OF FATHER: Abraham Hess
11 BIRTHPLACE OF FATHER (State or country): Carroll
12 MAIDEN NAME OF MOTHER: Darilla Feeser
13 BIRTHPLACE OF MOTHER (State or Country): Carroll

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Long
(Address) Damestown Md.

15 Filed ..... 192 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb 18, 1930 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 15 1930 to Feb 18, 1930
that I last saw h[illegible] alive on Feb 18, 1930
and that death occurred on the date stated above, at 10 P m.
The CAUSE OF DEATH * was as follows:

Cerebral Apoplexy

(Duration) ... yrs. ... mos. 3 ds.

Contributory Secondary: Cerebral Apoplexy
(Duration) ... yrs. ... mos. 3 ds.

(Signed) Geny A. Long M. D.
Feb 19 1930 (Address) 5631 Harford Rd

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Damestown Reformed | DATE OF BURIAL: Feb 21, 1930
20 UNDERTAKER: C. C. Hostetter | ADDRESS: Damestown

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

9 1930

Md

Spec.—2-29-28—L. F. S.—500 Blks.

E 54209

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 54209

CERTIFICATE OF DEATH

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. 15-K WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Gill

(a) RESIDENCE NO. 17 N. Schroeder ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) abt. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Not stated

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Stated

12 MAIDEN NAME OF MOTHER Not stated

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Stated

14 Informant George Gilson (son)

(Address) 17 N. Schroeder St

15 Filed FEB 19 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 16 1930

17 I HEREBY CERTIFY, That I attended deceased from February 14, 1930 to February 16, 1930, that I last saw her alive on Feb. 16, 1930 and that death occurred, on the date stated above, at 9.06 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis with cardiac decompensation

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) J. M. B. Schneider, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Feb. 19 1930
20 UNDERTAKER John M. Thomas	ADDRESS 2325 Madison Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54210

E 54210

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 2700 Hudson ST. 1-3 (WARD)

2-FULL NAME Maryanna Baranowski

(a) RESIDENCE. NO. 2700 Hudson ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36. yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 1875

7 AGE: Years 54 Months 8 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: John Baranowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Ursula Kurlinski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Fanny Baranowska (Address) 2700 Hudson St.

15 Filed 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 16 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 - 1930, to Feb 16, 1930, that I last saw h alive on Feb 15, 1930, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chr. Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. J. Davidow, M. D.

, 19 (Address) 3035 Odonnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem

DATE OF BURIAL: 2/20/30

20 UNDERTAKER: Stephen J. Tialkowski

ADDRESS: 1045 Keeman

TION is very important. See instructions on back of certificate.

3 19 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54211 100-001

CERTIFICATE OF DEATH

REGISTERED NO. E 54211

1—PLACE OF DEATH Md. General Hospital 13-52 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2—FULL NAME Nathan Swann

(a) RESIDENCE NO. 1009 W. 3rd ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/27/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79 80	10	22 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener & Florist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Swann

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Edith (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Hospital records
(Address)

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19/30

17 I HEREBY CERTIFY, That I attended deceased from 2/10, 1930, to 2/19, 1930, that I last saw h. alive on 2/19, 1930 and that death occurred, on the date stated above, at 12 05 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ... yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

Signature ... M. D.

(Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Cem. DATE OF BURIAL Feb 20 1930

20 UNDERTAKER William Cook ADDRESS 1217 St. Paul

Important. Use Instructions on Reverse Side.

FEB 19 1930

Spec.—1-30—M. & T.—250 Blks.

Dr Thos F. White 534 22nd St
Tenn 3846

E 54212

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54212

CERTIFICATE OF DEATH.

11-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2946 Greenmount Ave (Street or Ward) 47-50

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Hood

(a) RESIDENCE NO. 2946 Greenmount Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Chas W. Hood

6 DATE OF BIRTH (month, day, and year) 12/3/1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
77	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Dryosit N. Y.

PARENTS

10 NAME OF FATHER Hiram Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Sarah A Haight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Wallace Hood Son

(Address) 2946 Greenmount Ave

15 Filed FEB 19 1930. C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/16/30

17 I HEREBY CERTIFY, That I attended deceased from February 7, 1930, to February 16, 1930, that I last saw h alive on February 16, 1930, and that death occurred, on the date stated above at 12.30 a m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas F White M. D.

, 19 (Address) 502 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 2/19/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54213

CERTIFICATE OF DEATH.

101-001

E 54213

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 N Calvert St) (11-15 WARD)

2-FULL NAME Mrs S Morse

(a) RESIDENCE NO. 1039 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Stem Morse

6 DATE OF BIRTH (month, day, and year) March 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rochester Ny

PARENTS

10 NAME OF FATHER Wm B Morse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Rochester Ny

12 MAIDEN NAME OF MOTHER Frances Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Whitney B Morse

(Address) Rochester N.Y.

15 Filed ....., 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1929, to Feb 19, 1930,

that I last saw him alive on Feb 18, 1930,

and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ....yrs. ....mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory studies; physical findings.

(Signed) Geo. D. Rowe, M. D.

Feb 19 1930 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rochester NY

DATE OF BURIAL 2/19 1930

20 UNDERTAKER Nelson Cook

ADDRESS 1217 St Paul St

G. HAYWOOD JONES, M. D.

Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54214

E 54214

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 5 V 6

CITY OF BALTIMORE: (No. Franklin Sq Hosp WARD) 46-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Metcalfe

(a) RESIDENCE NO. 929 Hollins St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Metcalf

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Sugan Beef Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Francis Metcalf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lillie May Metcalf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Perkins (Address) 929 Hollins St

15 Filed FEB 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1930 to Feb. 18, 1930

that I last saw h/m alive on Feb. 18, 1930

and that death occurred, on the date stated above, at 4 50 p m.

The CAUSE OF DEATH* was as follows:

Terminal Hypostatic Pneumonia

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Hypertrophic Arthritis of Spine (duration) 10 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chinic picture

(Signed) Arthur Rattenni M. D.

2/18, 1930 Address Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 2/21, 1930

20 UNDERTAKER Chas P. Maus & Son ADDRESS 1520 N. Monroe St

Important: See instructions

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 54215

CERTIFICATE OF DEATH

E 54215 REGISTERED NO.

1—PLACE OF DEATH Provident Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division ST. 16-23 WARD)

2—FULL NAME Lucinda Tonkins

(a) RESIDENCE NO. 1106 N. Carrollton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillip A Tonkins

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42 41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Hampton (State or country) Va.

PARENTS

10 NAME OF FATHER David Bellamy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Jennie Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Phillip Tonkins (Address) 1106 Carrollton Ave

15 Filed C. HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby: 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 12, 1930, to Feby 16, 1930, that I last saw h or alive on Feby 16, 1930 and that death occurred, on the date stated above, at 6:15 a.m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(duration) yrs. mos. 16 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Carroll M. McClure, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 2/18, 1930

20 UNDERTAKER Samuel Stevenley

ADDRESS 508 Edlo

Important. See instructions on back of Certificate

FEB 19 1930

Spec.—8-16-29—L. F. S.—100 Bks.

Holland's ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54216 — CERTIFICATE OF DEATH — † 90 E 54216

1—PLACE OF DEATH Provident Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST 14 + 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Holland

(a) RESIDENCE NO. 22 Linwood ave ST. Catonsville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Holland

6 DATE OF BIRTH (month, day, and year) May 28, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55 / 56	8 / 7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Catonsville (State or country) Md

PARENTS

10 NAME OF FATHER Philip Woodland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Maryland

12 MAIDEN NAME OF MOTHER Sarah Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Maryland

14 Informant Edward Holland (Address) 22 Linwood ave

15 Filed 2/19/1930 C. HARRISON JONES, M. D. Registrar

Mar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17-30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1930, to Feb. 17, 1930, that I last saw h[illegible] alive on Feb. 17, 1930 and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Cardiac Decompensation

(duration) about 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. McClain, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star — DATE OF BURIAL Feb 24 30

20 UNDERTAKER Joseph A. Lively — ADDRESS 1021 N Monroe St

Important. See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Blks.

E 54217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓ E 54217

REGISTERED NO. 28-66

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Walnut Ave ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hamina H. Lowen

(a) RESIDENCE NO. 611 Walnut Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry L. Lowen

6 DATE OF BIRTH (month, day, and year) Oct 2 1869

7 AGE Years 60 Months 4 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Norristown

(State or country) Pa.

PARENTS

10 NAME OF FATHER Chas Eisenschmidt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Harry L. Lowen

(Address) 611 Walnut Ave

15 Filed FEB 9 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1930

17 I HEREBY CERTIFY, That I attended deceased from 8/2/27, 19, to 2/18/30, 19, that I last saw h alive on 2/17/30, 19, and that death occurred, on the date stated above, at 1045 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the bladder (malignant)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 11/15/29

Was there an autopsy?

What test confirmed diagnosis? autoscopic

(Signed) R E Goldstein M.D. M. D.

, 19 (Address) 3304 Chas Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemt

DATE OF BURIAL Feb 21 1930

20 UNDERTAKER Rentzel & Lee

ADDRESS 1723 W Lafayette Ave

Spec.—8-16-29—L. F. S.—100 Bks.

B 34003
B 54218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-00 E 54218

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Vienna

(a) RESIDENCE NO. 1102 E Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Mary Castina

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1 9 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-18-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930, to Feb 18, 1930, that I last saw him alive on Feb 18, 1930 and that death occurred, on the date stated above, at 3.10 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J W Beckford, M. D.

2/18, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer.

DATE OF BURIAL Feb 20 1930

20 UNDERTAKER Wendell J Dippel

ADDRESS 300 S. Eden st

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54219

CERTIFICATE OF DEATH.

E 54219

REGISTERED NO. 74-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 623 Granby ST. 16-70 (WARD)

2-FULL NAME Lottie Godfrey

(a) RESIDENCE NO. 623 Granby ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 8 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Godfrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Martha Cooley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Ida Leakins

(Address) 623 Granby St

15 Filed FEB 19 1930 C. HAMILTON COOPER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1930, to Feb 18, 1930.

that I last saw her alive on Feb 18, 1930.

and that death occurred, on the date stated above, at 1 15 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterial Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) L. A. Leaky M.D. M. D.

, 19 (Address) 351 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	Feb 20 1930
20 UNDERTAKER George J. Smith	ADDRESS 532 Hollins

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54220

CERTIFICATE OF DEATH

24-001 V

E 54220
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1819 Penna Ave (St.) 2-4-30 (Ward)

2-FULL NAME Paul Williams

(a) RESIDENCE NO. 1819 Penna Ave St., 21st Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mable Williams

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Raleigh Williams

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Dant Nixon

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Raleigh Williams
(Address) 1819 Penna Ave

15 Filed FEB 5 1930, 19... HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy) (duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) H. Leslie Corner, M. D.

Feb 4th 1930 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oceans Va	2-7 1930
20 UNDERTAKER Daniel Carter	ADDRESS 916 Pine

B OF DEATH in plain terms, so that it may be properly classified. Use important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54221

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54221

CERTIFICATE OF DEATH

REGISTERED NO. 66

1-PLACE OF DEATH

City of Baltimore: (No. En route to University Hospital Ward 9

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Carter

(a) RESIDENCE NO. 1601 Penna Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
28	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Ky

PARENTS

10 NAME OF FATHER W W Carter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Somerville Ky

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont Know

14 Informant W W Carter
(Address) Somerville K.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

2/19. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Somerville K Y

DATE OF BURIAL 2/20 1930

20 UNDERTAKER Edward Foulon

ADDRESS 2359 Ward Ave

OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54222

CERTIFICATE OF DEATH

E 54222

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 E. Baltimore ST., 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Winterling

(a) RESIDENCE NO. 1600 E. Baltimore ST., 6th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 9 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5 - 5 - 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cleaning Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER George Winterling

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Sophie Brickner

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs G. Plaenker

(Address) 1606 E. Baltimore St.

15 Filed 1930 C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to Feb 18, 1930, that I last saw him alive on Feb 17, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Feb 18, 1930 (Signed) J C Glendes, M. D.

(Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 2/20/1930

20 UNDERTAKER Louis Steemann

ADDRESS 32 S. Broadway

Spec.—8-16-29—L. F. S.—100 Bks.

E 54223 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 129 E 54223

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO. 47

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Z. Brown

(a) RESIDENCE NO. Buckingham Rd. near Liberty St. Hgts Av. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Brown

6 DATE OF BIRTH (month, day, and year) Aug 1st 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Painting Industry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. County

PARENTS

10 NAME OF FATHER Louis Z. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. County

12 MAIDEN NAME OF MOTHER Mary Ann Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. County

14 Informant Dr. Albertus Z. Cotton

(Address) St. Paul & Preston St.

15 Filed FEB 19 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18/30

17 I HEREBY CERTIFY, That I attended deceased from February 18, 1930, to February 18, 1930, that I last saw him alive on February 18, 1930, and that death occurred, on the date stated above, at 10-25 P. m.

The CAUSE OF DEATH* was as follows: Renal

Arteriosclerotic Cardiovascular Disease with Hypertension

(duration) about 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. 10 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Deane, M. D.

2/18/30 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL 2/22 1930

UNDERTAKER Chas. F. Wack & Son ADDRESS 1811 W. Royal Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54224 ✓ 101-00 E 54224

E 54224

CERTIFICATE OF DEATH

1—PLACE OF DEATH Md. General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 11-24 ST. WARD) REGISTERED NO.

2—FULL NAME Mae Rosebery

(a) RESIDENCE NO. Pikesville, Md. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (Husband of) (or) WIFE of: Henry Lee Rosebery

6 DATE OF BIRTH (month, day, and year): 2/1/06

7 AGE — Years: 24 | Months: 0 | Days: 18 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Fawn Township, Pa.

PARENTS

10 NAME OF FATHER: Lawrence Tompkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Jennie Grove

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Hospital records

(Address): C. THOMPSON JONES, M. D.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/19/30

17 I HEREBY CERTIFY, That I attended deceased from 2/17/30, 19.., to 2/19, 19 30

that I last saw h.r alive on 2/19, 19 30

and that death occurred, on the date stated above, at 7:40 p.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia complicating pregnancy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jno [illegible] Thompkins, M. D.

19 (Address) [illegible] Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fawn Grove Pa

DATE OF BURIAL: Feb 24 1930

20 UNDERTAKER: [illegible]

ADDRESS: Fawn Grove Pa

Important. See instructions.

3 19 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54225 ✓ 31 E 54225

E 54225

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Campbell

(a) RESIDENCE NO. 1128 Harford ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Campbell

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47 / 48		1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 06

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nelson T. Campbell

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alverta Randall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Hospital Recores

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25, 1930, to Feb. 18, 1930, that I last saw him alive on Feb. 18, 1930 and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos Gherardi Jr. M. D.

2-18, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Feb. 20, 1930

20 UNDERTAKER A. Howard Evans

ADDRESS 3[illegible] E Fort Ave

Spec.—8-16-29—L. F. S.—100 Blks.

E 54226

2371 N. Sum

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 84 ✓

E 54226

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles W. Coots

(a) RESIDENCE NO. 1416 Milan St. ST., WARD Houston Tex

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Auto - Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ky -

PARENTS

10 NAME OF FATHER Wilson E. Coots

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ky -

12 MAIDEN NAME OF MOTHER Mary Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky -

14 Informant Records -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

FEB 9 1930 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-19-30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1930, to Feb. 19, 1930, that I last saw him alive on Feb 19, 1930 and that death occurred, on the date stated above, at 11 15 a. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Glioma (Cytological)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 17-I-30

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) S H Complain, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Houston, Texas

DATE OF BURIAL Feb. 22, 1930

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Eutaw Pl.

Important: See instructions on reverse side.

Rev.—2-29-28—1. P. S.—500 Blks.

E 54227

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54227

CERTIFICATE OF DEATH

90

REGISTERED NO. 4469

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. 26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John R. Corns

(a) RESIDENCE NO. Mt Hope Retreat ST., 28th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced: BUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) abt. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	83	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fishing-Sailor

(b) General nature of industry, business, or establishment in which employed (or employer): Fishing 086

(c) Name of employer

9 BIRTHPLACE (city or town) (?)

(State or country) Maryland

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) Not Known

(State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant Records of Mt Hope Retreat

(Address) Mt Hope Baltimore

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 3rd, 1892, to Feb 19 - , 1930.

that I last saw him alive on Sept 18th, 1930

and that death occurred, on the date stated above, at 7.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - Senile Chr. Rheumatism

two or 3 yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dept Psychosis -

abt (duration) 38 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Maryland - (?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flemming, M. D.

Feb 19, 1930 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Cathedral Cemetery

DATE OF BURIAL: Feb 20 1930

20 UNDERTAKER: Stewart & Mowers Co. 1082 N. North Ave.

ADDRESS

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54228

CERTIFICATE OF DEATH

31 E 54228

1—PLACE OF DEATH Baltimore City Hospitals T.B. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 6 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Coston

(a) RESIDENCE NO. 1613 Mullikin st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearline Coston

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Viriniga

PARENTS

10 NAME OF FATHER William Coston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Dora Coston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed 2 19 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1930, to Feb. 16, 1930, that I last saw him alive on Feb. 16, 1930 and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) J. A. Stewart, M. D.

2-17, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem DATE OF BURIAL 7/21/1930

20 UNDERTAKER Robert Mullikin ADDRESS 1515 N Eden St

Cor.—10-10-29—A Co.—100 Bks.

E 54229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 54229

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 20 N. Eden St. 5-8 Ward)

2-FULL NAME Robert Bragg

(a) RESIDENCE NO. 135 Bruce St., Portsmouth, Va. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Bragg

6 DATE OF BIRTH (month, day, and year) 1877?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Beaufort, N.C.
(State or country)

PARENTS

10 NAME OF FATHER Albert Bragg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Caroline Tolson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Orcracoka Island. N

14 Informant Mrs. A. Hyde (sister)
(Address) 20 N. Eden St

15 Filed ..... 19 .....
Registrar

B 1 9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Valvular Insufficiency
(Aortic)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Diag-Hopkins Hosp.

(Signed) [signature], M. D.
2/19/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portsmouth Va

DATE OF BURIAL Feb 20 1930

20 UNDERTAKER F Vernon Meehner

ADDRESS 1532 Hollins

OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54230

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 ✓ E 54230

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2433 E. Federal ST.) 8-16 (WARD)

2—FULL NAME Sallie A. Jefferson

(a) RESIDENCE NO. 2433 E. Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Jefferson

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila. Pa

PARENTS

10 NAME OF FATHER Chas Reese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Phila. Pa

12 MAIDEN NAME OF MOTHER Josephine Fussell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. S. Jefferson

(Address) 2433 E. Federal St

Filed FEB 19 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19-1930

17 I HEREBY CERTIFY, That I attended deceased from December 7, 1929 to February 19, 1930, that I last saw her alive on February 19, 1930 and that death occurred, on the date stated above, at 0.35 a.m.

The CAUSE OF DEATH* was as follows:

(a) Acute Bronchitis.

(b)

(c)

(duration) 1 yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Nephritis + Cerebral Oedema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination + Examination

(Signed) Elliott Rosenberg M.D.

(Address) 2025 North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL Feb. 22 1930

20 UNDERTAKER John C. Miller — ADDRESS 2435 E Oliver

Cor.—10-10-29—A

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54231

CERTIFICATE OF DEATH

90 E 54231

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 116 S. Carey St., 19-29 Ward)

2-FULL NAME Concetta Messina

(a) RESIDENCE NO. 116 S Carey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmale	Wh	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Messina

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 637
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Guy Napoli

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Frank Messina
(Address) 1032 Hanover

15 Filed 1930 C. HAMPSON JONES, Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'D Brooke M. D.

Feb 15. 1930 (Address) 3601 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	2/20/30
20 UNDERTAKER	ADDRESS
J. B. Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54232 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 54232

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME ~~Charlo e Mayao~~ Charles Ulchinskey

(a) RESIDENCE NO. The Anchorage, S. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 1 mos. 16 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan. 2, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Able seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman 686

(c) Name of employer SS Firmore

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Anthony Mayao

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Agnes ?

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Lithuania

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Filed FEB 19 1930, 19... C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 11, 19 29, to February 18, 19 30, that I last saw him alive on February 18, 19 30, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, active

..... (duration) unknown yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Tuberculosis of larynx

..... (duration) unknown yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? x-ray, lab. & clinical

(Signed) Ralph L. Porter, M. D.

2/19 19 30 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 2/20 1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 E. Pratt St

Spec.—2-29-28—L. F. S.—500 Blks.

E 54233

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54233

CERTIFICATE OF DEATH

REGISTERED NO. 19-28 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 318 S. Bruce ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter A Ruckle

(a) RESIDENCE NO. 318 S Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ruckle

6 DATE OF BIRTH (month, day, and year): July 1871

7 AGE: Years 58 | Months 7 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward A Ruckle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md

12 MAIDEN NAME OF MOTHER: Christina Clemens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Geo E Ruckle

(Address) 1627 Clifton Ave

Filed 1 9 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19/30

17 I HEREBY CERTIFY, That I attended deceased from 2/18, 1930, to 2/19, 1930, that I last saw h— alive on 2/19/30, 19..., and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Arteriosclerosis

Hypertension two yrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? usual

(Signed) Leonard J. Levy, M. D.

2/19, 1930 (Address) 910 W London

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 2/21 1930

20 UNDERTAKER: Jno Cook

ADDRESS 1317 E Pratt St

C. HAMPSON JONES, M.D.

Spec.—1-30—M. & T.—250 Blks.

Dr Grady 4218 Harford Rd

E 54234

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54234

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3630 Old York Rd ST. 12-49 (WARD)

2-FULL NAME Elizabeth Davis

(a) RESIDENCE NO. 3630 Old York Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel Davis

6 DATE OF BIRTH (month, day, and year) Sept. 22. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary O Leonhardt

(Address) 3017 Powhatan Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 3rd, 1930, to Feb 18, 1930, that I last saw her alive on Feb 17th, 1930, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. L. Grady, M. D.

Feb 18, 1930 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 21 1930

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul St

FEB 19 1930 HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

Dr Diehl
1224 Hanover St
10-001

E 54235 HEALTH DEPARTMENT—CITY OF BALTIMORE 10 E 54235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3906 Hanover St. 25-7 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances G. Floyd

(a) RESIDENCE No. 3906 Hanover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	4	4 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James A. Floyd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Gertrude Bailey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant James A. Floyd
(Address) 3906 Hanover St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1930, to Feb. 19, 1930, that I last saw her alive on Feb. 18, 1930, and that death occurred, on the date stated above, at 8 A- m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ....yrs. ....mos. V ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry Diehl M. D.

. 19 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL Feb 21 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Blks.

E 54236 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54236

CERTIFICATE OF DEATH.

129

REGISTERED NO. 12-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 442 W. Conway ST. (WARD)

2-FULL NAME Sarah Langford

(a) RESIDENCE NO. 442 W Conway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. — mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur Langford.

6 DATE OF BIRTH (month, day, and year) Feb 8 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Newman

11 BIRTHPLACE OF FATHER (city or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Tyler

13 BIRTHPLACE OF MOTHER (city or town) Ga

(State or country) Maryland

14 Informant Martha Brown

(Address) 442 W Conway

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb - 18 - 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/9, 1930, to 2/18, 1930,

that I last saw her alive on 2/18, 1930,

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy,

(duration) — yrs. — mos 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) Chronic yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine +++

(Signed) Dan Trautman M. D.

2/18 1930 (Address) 1212 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2-20 1930

20 UNDERTAKER Dennett Carter

ADDRESS 916 Eutaw

Spec.—2-29-28—L. F. S.—500 Blks.

E 54237

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 34237

CERTIFICATE OF DEATH

31 VE 54237

1—PLACE OF DEATH Baltimore City Hospitals ST. 77-130 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST.

2—FULL NAME John Hankins (Hawkins)

(a) RESIDENCE NO. 441 W. Conway st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36 35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Hankins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 [illegible] JONES, M. D. Registrar

FEB 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1930, to Feb. 19, 1930, that I last saw him alive on Feb. 19, 1930 and that death occurred, on the date stated above, at 12.35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Stinson M. D.

2-19 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Auburn Cem

DATE OF BURIAL 2-20 1930

20 UNDERTAKER Daniel Easton

ADDRESS 916 Ca ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54238

E 54238

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 33rd & Calvert Sts ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis a. white.

(a) RESIDENCE NO. 3804 Greenway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced (or) WIFE of Sarah Poultney Ellicott

6 DATE OF BIRTH (month, day, and year) Dec. 4th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Francis White

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Jane Janney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hospital Records

(Address)

15 Filed FEB 20 1930 MARION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to Feb 14, 1930

that I last saw h[illegible] alive on Feb 14, 1930

and that death occurred, on the date stated above, at 11.35 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis unknown.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical symptoms.

(Signed) Francis W. Black, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL Feb 21 1930

20 UNDERTAKER Lemmon & Jenkins Funeral Chapel

ADDRESS N. Gilmor & Lanvale

Important: See instructions on back

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54239

CERTIFICATE OF DEATH

E 54239

REGISTERED NO. 12-49

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital) WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Marion Ellis

(a) RESIDENCE NO. 4429 Trias St. ST., WARD San Diego, Cal.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard Ellis

6 DATE OF BIRTH (month, day, and year) Aug. 7, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hartford Conn.

PARENTS

10 NAME OF FATHER James H. Tallman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Alice E. Graves.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant Husband.

(Address)

Filed FEB 20 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 13, 1929, to Feb. 19, 1930, that I last saw h[illegible] alive on Feb. 18, 1930, and that death occurred, on the date stated above, at 4:35 A. m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer with pyloric obstruction

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis + obstruction

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Dec. 17, 1929 / Jan. 7, 1930 / Jan 17, 1930

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical symptoms + autopsy.

(Signed) Nicholas Sanpovard, M. D.

Feb 19, 1930 (Address) Union Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hartford Conn.

DATE OF BURIAL Feb 20th 1930

20 UNDERTAKER Kenny Hutchinson

ADDRESS McClellan Street

Important. See instructions on the reverse side.

Spec.—8-16-29—L. F. S.—100 Blks.

Jamres.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54240

CERTIFICATE OF DEATH

131 ✓

REGISTERED NO. E 54240

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 5-West WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Allen Tamres

(a) RESIDENCE NO. 1707 Warwick ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 3-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS

10 NAME OF FATHER Louis Tamres

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sara Kasch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Tamres

(Address) 1707 Warwick ave

15 Filed ——— 19 ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930, to Feb 20, 1930, that I last saw him alive on Feb 20, 1930 and that death occurred, on the date stated above, at 4.55 a m.

The CAUSE OF DEATH* was as follows:

Acute syphilis with high elevation of temperature began on 9th day of life

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Septicemia developed on 11th day

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine & Blood cultures

(Signed) J. Frank Hewitt M. D.

2/20. 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Sholom

DATE OF BURIAL 2/20 1930

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Baltimore St

IMPORTANT.—See instruction on reverse side.

FEB 20 1930 HARRY JONES M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54241 ✓ E 54241 ✓

E 54241 100-001

CERTIFICATE OF DEATH

REGISTERED NO. 11-24

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Lindsay ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Lloyd

(a) RESIDENCE NO. 1207 Lindsay ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Lloyd

6 DATE OF BIRTH (month, day, and year) Feby 17. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Sheilds

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Hubbard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Mrs. Sophia L. Saunders

(Address) 518 Potomac Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 18 1930

17 I HEREBY CERTIFY, That I attended deceased from February 9th, 1930, to February 14th, 1930, that I last saw h[illegible] alive on February 18th, 1930, and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 1 yrs. 7 mos. 8 da.

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis (duration) — yrs. — mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar D. Perkins, M. D.

19 (Address) 1 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem.

DATE OF BURIAL Feby 20 1930

UNDERTAKER John O Mitchell & Son

ADDRESS 1900 Eutaw Place

Spec.—1-10-21—M&T—1500 Blks.

Frist

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54242

E 54242

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2913 Riggs ave 16-67 WARD)

2-FULL NAME Margaret Anna Arthur Frist

(a) RESIDENCE NO. 2913 Riggs ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced (or) WIFE of: John E Frist

6 DATE OF BIRTH (month, day, and year): July 9 1859

7 AGE: Years 70 Months 7 Days 10. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Not any

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: John P. Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Maria Maroney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs. Anna L. Jamison 2913 Riggs Ave

15 Filed FEB 11 1930 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 7 1929 to Feb 9 1930.

that I last saw he alive on Feb 6 1930,

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis & Uremia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis interstit

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) H. Hanson Jones, M. D.

, 19 (Address) 3200 Loyola Blvd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Feby 21 1930

20 UNDERTAKER: John O. Middleton & Son

ADDRESS 1900 Eastern Ave

CAUSE OF DEATH in plain English. ATTENTION is very important. See instructions on back of certificates.

Spec.—2-29-28—I. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 54243

E 54243

CERTIFICATE OF DEATH

REGISTERED NO. 77-53

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Charles T. Foster

(a) RESIDENCE NO. 225 Hawthorn road, Roland Pk. Balto., Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer in bulky bags

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Wm T Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Virginia.

12 MAIDEN NAME OF MOTHER Angeline Rider

13 BIRTHPLACE OF MOTHER (city or town) Balt. Co. (State or country) Maryland

14 Informant Wife

(Address) 225 Hawthorn Road, Roland Pk. Balto. Md.

Important. See instructions on back.

15 Filed FEB 20 1930 16 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18, 1930

17 I HEREBY CERTIFY. That I attended deceased from Feb. 17, 1930, to Feb. 18, 1930 that I last saw h alive on Feb. 18, 1930 and that death occurred, on the date stated above, at 9 30 P.m.

The CAUSE OF DEATH* was as follows:

Abdominal malignancy & metastasis to liver and ascites - Cachexia

(duration) Undetermined yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) W. H. Hayward Jr., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Feby 21 1930

UNDERTAKER John O Mitchell and Son

ADDRESS 1900 Eastern Ave

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54244

E 54244

CERTIFICATE OF DEATH

REGISTERED NO. 74-00

1—PLACE OF DEATH
CITY OF BALTIMORE (No.) South Baltimore Gen. Hosp. ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Russell Wroten

(a) RESIDENCE NO. 120 E. Montgomery ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	3	16	

8 OCCUPATION OF DEACESED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS
10 NAME OF FATHER Jos. E. Wroten
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Linda A. Williams
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Mrs. M. Lemmerman
(Address) 120 E. Montgomery St.

15 FEB 20 1930 H. AMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19-30

17 I HEREBY CERTIFY, That I attended deceased from 2-15, 1930, to 2-19, 1930
that I last saw h[illegible] alive on 2-19, 1930
and that death occurred, on the date stated above, at 1.45A. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical findings

(Signed) Joseph Laukaitis, M. D.
(Address) South Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park. DATE OF BURIAL Feb 22, 1930

20 UNDERTAKER Fred A. Klausen ADDRESS 703 Monroe St.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54245

CERTIFICATE OF DEATH.

129 E 54245

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 730 George ST., 17-24 WARD

2-FULL NAME Archer B. Owens

(a) RESIDENCE NO. 730 George ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Owens

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: Years 64; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurseryman

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Jordan Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Martha —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Emma Owens

(Address): 730 George

15 Date Received: FEB 20 1930 Registrar: H. JAMES JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-17-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to Feb 17, 1930, that I last saw h[illegible] alive on Feb 16, 1930, and that death occurred, on the date stated above, at 11A m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 1 yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) [illegible], M. D.

(Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL 2/20/1930

UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave

CAUSE OF DEATH. See instructions on back of certificate.

TION is very important.

Spec.—2-21-28—L. F. S.—500 Blks.

E 54246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 54246

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2—FULL NAME Lee Kim

(a) RESIDENCE NO. 201 S. Conklin st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Yellow	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundryman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) China

PARENTS

10 NAME OF FATHER Lee Wy

11 BIRTHPLACE OF FATHER (city or town) (State or country) China

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) China

14 Informant Hospital Records (Address)

15 FEB 20 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1930, to Feb. 16, 1930, that I last saw him alive on Feb. 16, 1930 and that death occurred, on the date stated above, at 11.25 p. m.

The CAUSE OF DEATH* was as follows: Myocarditis - Acute + Chronic

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Unknown

What test confirmed diagnosis? Clinical

(Signed) M. D.

2-17, 19 30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 19 1930
20 UNDERTAKER John F Denny	ADDRESS 752 Light St

Spec.—1-30—M. & T.—200 Blks.

E 54247 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 84

E 54247

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1712 E. 33rd St. (Ward) 9-47

2-FULL NAME Henry Dittman

(a) RESIDENCE NO. 1712 E. 33rd St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdalena Dittman

6 DATE OF BIRTH (month, day, and year) Jan 14 1891

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Dittman Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Katzenmaier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Magdalena Dittman

(Address) 1712 E. 33rd St.

15 Filed FEB 20 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to Feb. 18, 1930, that I last saw him alive on Feb. 18, 1930, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Multiple Sclerosis

acute infection

(duration) 15 mos — da.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. C. Hyams M. D.

19 (Address) 16 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL Feb 21 1930

20 UNDERTAKER Philip Henry — ADDRESS 2019 Eutaw Pl

Spec.—2-29-28—L. F. S.—500 Blks.

E 54248

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54248

CERTIFICATE OF DEATH

100-001

REGISTERED NO.

1—PLACE OF DEATH Md. General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 15-67 ST. (OR AVE.) WARD

2—FULL NAME Wm. M. Griffith

(a) RESIDENCE NO. 310 S Wallbrook Hurst. (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 11 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Wm. Griffith

6 DATE OF BIRTH (month, day, and year) 2/21/1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
99	78	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Nancy Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Records

(Address)

15 FILED FEB 20 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19/30

17 I HEREBY CERTIFY, That I attended deceased from 2/18, 19 30, to 2/19, 19 30, that I last saw h[illegible] alive on 2/19, 19 30 and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

2/19/30 (Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Feb 21 30

20 UNDERTAKER Stewart & Mowen Company — ADDRESS 108 W. North Ave.

Important: See instructions on reverse side.

Spec.—1-30—M. & T.—250 Blks.

E 54249 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54249

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ST 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Diggs

(a) RESIDENCE NO. 616 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Norma Diggs

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 19 H. HARRISON JONES, M. D. Registrar

B 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-18-30

17 I HEREBY CERTIFY, That I attended deceased from 6-13-29, 19..., to 2-18-30, 19...,

that I last saw him alive on 2-18-30, 19...,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Syphilis over 1 yrs. ... mos. ... ds.

(duration)

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? W & R

(Signed) Harris M. McClean, M. D.

2-19, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 2/20 1930

20 UNDERTAKER Samuel T. Hende

ADDRESS 528 N Eutaw

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54250

CERTIFICATE OF DEATH

1929

E 54250

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 624 Sarah Ann St., 4-25 Ward)

2-FULL NAME Mary E. Carter

(a) RESIDENCE NO. 624 Sarah Ann St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work athoma good
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Annie Owens
(Address) 2343 Druid Hill Ave

15 Filed ..... 19.. C. HAMPTON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Cottrell M. D.

2/20, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Peters Cem.

DATE OF BURIAL 2/22 1930

20 UNDERTAKER Conrad & Stanley

ADDRESS 1424 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement important. See instructions on back of certificate.

FEB 20 1930

Spec.—2-29-28—L. F. S.—500 Bks.

Buhman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54251

CERTIFICATE OF DEATH

24-001

E 54251

REGISTERED NO. 15-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Helen T Buhman

(a) RESIDENCE NO. 1602 W North Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Buchman

6 DATE OF BIRTH (month, day, and year) June 7 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	8	11	
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Augustus J Kruse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Augustus Kruse

(Address) 1602 W North Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18/30

17 I HEREBY CERTIFY, That I attended deceased from 11/23, 1930, to 2/18, 1930,

that I last saw h[illegible] alive on 2/18, 1930

and that death occurred, on the date stated above, at 10-50 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, generalized

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/16/30

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Thos. E. Stacy Jr, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Feb 22 1930

20 UNDERTAKER Jonah Lyser

ADDRESS 1602 W North Ave

Important. See instructions on back of

B 20 1930

Spec.—1-30—M. & T.—250 Bks.

E 54252

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54252

CERTIFICATE OF DEATH.

REGISTERED NO. 1001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 E. Chase ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Garrity

(a) RESIDENCE NO. 712 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress maker 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Garrity

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Marie Garrity (Address) 712 E. Chase St.

15 Filed 2-07-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18 - 30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1925, to Feb. 18, 1930,

that I last saw h[illegible] alive on Feb 18, 1930,

and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Cystitis Uraemia

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Hemorrhages

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) Stanislaus McGeorge, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Feb. 21 '30

20 UNDERTAKER Rita Mrodefeld

ADDRESS 914 Fremont Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54253

CERTIFICATE OF DEATH

REGISTERED NO. 90 E 54253

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte Carroll

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER William Whibey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Margaret Whibey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St

15 Filed 3 20 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1930 to Feb 18 1930

that I last saw h[illegible] alive on Feb 17 1930

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Contributory (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) General Anasarca (duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Bernardoyz M. D.

Feb 20 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Feb 21 1930

20 UNDERTAKER Ritz Macdefield

ADDRESS 914 Gre[illegible]

THOMPSON PRINTS, M[illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54254

CERTIFICATE OF DEATH.

E 54254

REGISTERED NO. 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Caroline Rabin ST. (or) WARD

2-FULL NAME Mrs. Mary E. Meinecke

(a) RESIDENCE NO. 514 E. 41st ST., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of the late Frederick C. Meinecke

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1850

7 AGE: Years 79; Months 1; Days 30 (24); If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pittsburg Pa

PARENTS

10 NAME OF FATHER: Samuel Tupper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Meinecke

(Address): 514 E. 41st St.

15 Filed: FEB 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-16, 1930, to 2-19, 1930, that I last saw h[illegible] alive on 2-19, 1930, and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Gangrenous appendicitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 2-16-30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) M. Blumberg, M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairmount Cemetery

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER: George Schilling & Sons 12 E. 41st

B 20 1930

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54255 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 54255

REGISTERED NO. 12-50

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2841 St Paul ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosetta M. Roberts

(a) RESIDENCE NO. 2841 St Paul ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 5 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Any old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Roberts

11 BIRTHPLACE OF FATHER (city or town) Wales
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Griffiths

13 BIRTHPLACE OF MOTHER (city or town) Wales
(State or country)

14 Informant Walter G Roberts
(Address) 2841 St Paul

15 Filed Feb 20 1930 C. HAMPSON JONES, M. D. Registrar By ARS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 14 1930, to Feb 19 1930, that I last saw h. alive on Feb 19 1930 and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Secondary
Carcinoma of Pleura
Rt Lung
(duration) 2 yrs. — mos. — da.

CONTRIBUTORY (Secondary) Carcinoma of Breast
(duration) 4 yrs. — mos. — da.

18 Where was disease contracted if not at place of death? Rt Breast Removed

Did an operation precede death? Yes Date of 3 yrs ago

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Jeffries Buck, M. D.

2/20 1930 (Address) 2844 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Feby 22 30
20 UNDERTAKER John O. Mitchell and Sons.	ADDRESS 1910 Eden St

Important. See instructions on back

3 20 1930

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) Throughout House ST. 1506 WARD

2-FULL NAME Baby Boy Littiri

(a) RESIDENCE NO. 3013 W Garrison ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wh	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 2 19 30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) Child
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Jerry Littiri

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Annie Labbee

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Russia

14 Informant Family
(Address) ...

15 Filed 2 20 1930 C. HAMPSON JONES M. D. Registrar

CAUSE OF DEATH must be given. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-18-30, 19..., to 2-19-30, 19...,
that I last saw h[illegible]live on 2-19-30, 19..., at 6 P. m.
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:
Encephalocele
Encephalocele

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Regurgitation
(duration) ... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Congenital
Did an operation precede death? No Date of ...
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy

(Signed) M. Hendrix M. D.
, 19 (Address) At Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL ... 19

20 UNDERTAKER Undertaker Board — ADDRESS FEB 20 1930

Per Jas E Woodall

Spec.—2-29-28—L. F. S.—500 Bks.

E 54257

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54257

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 E 21st St., WARD) 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Corley Coffey

(a) RESIDENCE NO. 520 E 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of John Coffey

6 DATE OF BIRTH (month, day, and year) 11-29-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Corley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Joseph B. Dunn

(Address) 501 E 31st St

20-1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/18/30

17 I HEREBY CERTIFY, That I attended deceased from August 29 to 2/18, 1930

that I last saw h... alive on 2/18, 1930

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J Riley M. D.

, 19 (Address) 532 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Feb 21 19 30

20 UNDERTAKER Mary M. Wadsack

ADDRESS 501 E 22nd St

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54258

CERTIFICATE OF DEATH

129 E 51258

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3205 Beverly Rd (Street) 27-41 (WARD)

2—FULL NAME Wilhelmina Schlegel

(a) RESIDENCE NO. 3205 Beverly Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec [redacted] 1852

7 AGE	Years	Months	If LESS than 1 day, hrs. or min.
	77		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Bockelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Cunice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Andrew Schlegel (Address) 3205 Beverly Rd

15 Filed FEB 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19, 30

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to Feb 18, 1930, that I last saw h[illegible] alive on Feb 18, 1930 and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstetium Nephritis + Rupture of Brain

Do my Homeopathy from Jan 18, 30

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Dr Mother, M. D.

Feb 19 1930 (Address) 3018 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL Feb 21 1930

20 UNDERTAKER George J. Smith

ADDRESS 1531 Hollins

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54259 | CERTIFICATE OF DEATH | 129 E 54259

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4108 N. Charles ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate E. McCubbin

(a) RESIDENCE NO. 4108 N. Charles ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 18 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William W. McCubbin

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William J. Delcher

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara A. Loury

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.

(State or country) Maryland

14 Informant Mrs. Robert H. Simpson

(Address) 4108 N. Charles Street

15 Filed 2 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 1930, to Feb 19 1930, that I last saw h alive on Feb 19 1930 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage causing Coma & Right Hemiplegia

(duration) — yrs. — mos. 11 da.

CONTRIBUTORY (Secondary) Ch. Lobar Pneumonia (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stephen Bruce M. D.

2/22/30 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 2/22 1930

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 803 N. Calvert

Important. See instructions on back.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54260

CERTIFICATE OF DEATH

E 54260

REGISTERED NO. E 54260

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2803 (Street) Chelsea Terrace (Ward) 15-61

2—FULL NAME Hubert Krebel

(a) RESIDENCE NO. 2803 (Street) Chelsea Terrace (Ward)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: Ruth Timmins

6 DATE OF BIRTH (month, day, and year): Dec 25th 1906

7 AGE — Years: 23 — Months: 1 — Days: 23 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel Co.
(c) Name of employer: Bethlehem Steel Co.

9 BIRTHPLACE (City or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Hubert Krebel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rosa Kuhnz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hubert Krebel
(Address) 2803 Chelsea Terrace

15 Filed FEB 20 1930 — C. HAMPSON JONES, M. D. Registrar — Reg. No. 6654

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 18 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930, to Feb 18, 1930; that I last saw him alive on Feb 18, 1930, and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Acute Myocardial Degeneration (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. Luichel, M. D.

Feb 18 1930 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Feb 21st 1930

20 UNDERTAKER: H. S. Wippert — ADDRESS: 1650 W. Baltimore St

Spec.—8-16-29—L. F. S.—100 Bks.

E 54261

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54261

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 27-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Riddlemoser

(a) RESIDENCE NO. 6209 Blackburn Lane ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Paul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Walf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. 19 Registrar

FEB 20 1930 By ACR

Important. See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Feb 20, 1930, that I last saw him alive on Feb 20, 1930 and that death occurred, on the date stated above, at 1 10 A. m.

The CAUSE OF DEATH* was as follows:

Brain Abscess, Right Cerebral (Staphylococcus aureus)

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Rupture Tabescent intestines

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/19/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & autopsy

(Signed) Clarence E. Gardner F. M.D.

2/20, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 2/21/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54262

CERTIFICATE OF DEATH.

E 54262

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 3019 Northway ST. 27-43 WARD

2-FULL NAME Baby Hendricks

(a) RESIDENCE NO. 130 Catalpa ave ST., Dundalk WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry B. Hendricks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret F Wilkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mother

(Address) 130 Catalpa ave, Dundalk

15 2 0 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 19th, 1930, to Feb 19, 1930, that I last saw him alive on Feb 19th, 1930, and that death occurred, on the date stated above, at 10 30 p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. dys.

CONTRIBUTORY (Secondary) Severe Injuries of mother (duration) hrs. days.

Existing one Periods of Forceps

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Benson, M. D.

2/19, 1930 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 2/21 1930

20 UNDERTAKER Wm Cook

ADDRESS 127 St Paul St

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—1-30—M. & T.—250 Bks.

2538 Harford Ave

E 54263 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 54263

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1243 E. Lanvale ST. 9-18 WARD)

2-FULL NAME George G. Myers

(a) RESIDENCE NO. 1243 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Myers

6 DATE OF BIRTH (month, day, and year) July 26 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer Pennsylvania R R.

9 BIRTHPLACE (city or town) Gettysburg (State or country) Penna

PARENTS

10 NAME OF FATHER Geo W Myers

11 BIRTHPLACE OF FATHER (city or town) Gettysburg (State or country) Penna

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Gettysburg (State or country) Penna

14 Informant Elizabeth Myers (Address) 1243 E Lanvale St.

15 Filed 2 0 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to Feb 18, 1930, that I last saw h[illegible] alive on Feb 18, 1930, and that death occurred, on the date stated above, at 6.20 P.m.

The CAUSE OF DEATH* was as follows:

Angio cardiac Insufficiency

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Cardiac asthma

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman M.D.

2/20 1930 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gettysburg Penna — DATE OF BURIAL Feb 22 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

HANSON JONES, M.

Cor.—10-10-29—A Co.—100 Bks.

VE. 8-4264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54264

90 E 54264

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 8 E. Franklin St. St., 14-70 Ward)

2-FULL NAME Charles E. Bodley. (C)

(a) RESIDENCE NO. 2011 Druid Hill Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. —mos.—dys—How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Divorced.

5a If ~~married, widowed~~, or divorced HUSBAND of ~~XXXXXXXX~~ Annie Bodley. (C)

6 DATE OF BIRTH (month, day, and year) October 14, 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	40	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER Charles E. Bodley. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie E. Foote. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Annie E. Bodley. (C) mother.
(Address) 1504 Madison Ave.

15 Filed ..... 19.. C. HARRY JAMES, M. D. Registrar
FEB 21 1930 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 18, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leinhardt, M. D.

2/19. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. M. Coleburn Sons — DATE OF BURIAL 2/24 30

20 UNDERTAKER Charles Alexander — ADDRESS 1406 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Have statements important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001E 54265

E 54265

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1208 mc Culloh St., 11-24 Ward)

2-FULL NAME Mary Rosie White.

(a) RESIDENCE NO. 1268 mc Culloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 Color or Race Col | 5 Single, Married, Widowed or Divorced, (write the word) Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1887-

7 AGE 43 Years 42 | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Wesley Parker

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hebron

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Louis Parker
(Address) Mitchellville R. F. D. 2

15 Filed ..... 19..... H. [illegible] JONES, M. D.
Registrar

FEB 21 1930 C. HARRY JONES, M. D.

Ref. 1244

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) ..... yrs. Sudden

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Regular

Signed [illegible] M. D.
(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. | DATE OF BURIAL 2/21 1930

20 UNDERTAKER Samuel Hensley | ADDRESS 538 Be[illegible]

OF DEATH in plain terms, so that it may be properly classified. Entries must be made in ink. Please write plainly. Use no abbreviations. All questions are important. See instructions on back of certificate.

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54266

CERTIFICATE OF DEATH.

E 54266

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4124 Walbrook St. 20-71 (WARD)

2-FULL NAME Frank J Ripple

(a) RESIDENCE NO. 4124 Walbrook Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 1857

7 AGE Years 72 Months 6 Days 5 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Gdr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER John Fr Ripple

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Rohrbacher

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Lee Ripple (Address) 4124 Walbrook

Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 17 1930

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1930, to Feby 17, 1930, that I last saw him alive on Feby 17, 1930 and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) yrs. mos. 48 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry J Stahmer, M. D.

3/19, 1930 (Address) 4111 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL 2 Mar 30

20 UNDERTAKER Geo A Tinley ADDRESS Fulton & Fayette

TION is very important See instructions on back of certificate.

B 2 1930 HAMILTON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 54267

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54267

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (NO. Baltimore, Md ST. 15-60

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank F Bentz

(a) RESIDENCE NO. 1708 Riverton Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mrs Frank F. Bentz

6 DATE OF BIRTH (month, day, and year) Nov 20 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	49	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) do not know

(c) Name of employer do not know

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo. Bentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) 1808 Riverton Ave

15 Filed FEB 21 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19-1930

17 I HEREBY CERTIFY, That I attended deceased from 2-17-1930, to 2-19-1930,

that I last saw her alive on Feb 19 - 1930

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Regurgitation of Cardiac Valves

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Spinal puncture

(Signed) J. V. Cologna, M. D.

, 19 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 2/22/30

20 UNDERTAKER Enoch Foley Funeral Home

ADDRESS

G. HAMILTON JONES, M. D.

Registrar

TION is very important See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54268 E 54268

54268

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4434 Forest View Ave ST., 26-42 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Zulauf

(a) RESIDENCE NO. 4434 Forest View Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E.

6 DATE OF BIRTH (month, day, and year) June 3-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Broom maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Zech unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Koepper

(Address) 4432 Forest View Ave.

15 Filed 2-1 1930 19 H. LAMPE REGISTRAR, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930, to Feb 20, 1930,

that I last saw h alive on Feb 19, 1930,

and that death occurred, on the date stated above, at 9 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [illegible], M. D.

2/20, 1930 (Address) Mapleaire Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorf Lawn Cem. DATE OF BURIAL 2/22 1930

20 UNDERTAKER William Cook ADDRESS 1217 St Paul St

Car

Cor.—10-10-29—A Co.—100 Bks.

E 54269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

160 E 54269

REGISTERED NO. 22-30

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 519 S. Grove St., Ward

2-FULL NAME Catherine Coats

(a) RESIDENCE NO. 519 S. Grove St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 15-1930

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Coats

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Myers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Sarah Myers
(Address) 519 S. Grove St

15 Filed (Signed) C. HARRISON JONES, M. D. Registrar
By

B 2 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus due to Malnutrition

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zollyd, M. D.

2/20. 1930 (Address) 2739 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkridge Md

DATE OF BURIAL Feb-21 1929

20 UNDERTAKER J L Brown & Son

ADDRESS 108 N. Monday

OF DEATH in plain terms, so that it may be properly classified. Entries must be full and important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 54270

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001 E 54270

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 24-35 S. (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Morgan

(a) RESIDENCE NO. 1214 Towson St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Morgan

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Wilson B. Morgan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa E. Hamel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Records of

Informant

(Address) Balto. City Hospitals

15 Filed 2-21 1930 C. H. Robertson, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20-30

17 I HEREBY CERTIFY, That I attended deceased from 2-18-30, 19..., to 2-20-30, 19...,

that I last saw him alive on 2-20-30, 19...,

and that death occurred, on the date stated above, at 9:40 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Gastric Ulcer

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

2-20, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Feby 22 1930

20 UNDERTAKER Henry Adreck Sons Inc — ADDRESS 1301 E Eager St

HON. EVERY Importance

Spec.—1-30—M. & T.—250 Bks.

E 54271 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 54271

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1651 S. Hanover St. (23-32 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karl Julius Kriewald

(a) RESIDENCE NO. 1651 Hanover St. Glen Burnie Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa A. Kriewald

6 DATE OF BIRTH (month, day, and year) Oct. 9 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Kriewald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs Louisa A Kriewald Glen Burnie Md

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5 ..., 1930, to Feb 19 ..., 1930, that I last saw him alive on Feb. 17 ..., 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows: Senile Myocarditis

(duration) ... yrs. ... mos 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hawkins M. D.

2/20 1930 (Address) 1651 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL Feb 22 1930

UNDERTAKER Wm Heckner Sons ADDRESS Norfolk Va

Spec.—1-30—M. & T.—250 Bks.

E 54272 HEALTH DEPARTMENT—CITY OF BALTIMORE 74 001

CERTIFICATE OF DEATH.

E 54272

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3936 Norfolk Ave ST. 15-6 WARD

2-FULL NAME John Randolph Cutchin

(a) RESIDENCE NO. 3936 Norfolk Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora N. Cutchin

6 DATE OF BIRTH (month, day, and year) Mar. 11 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1925

(c) Name of employer Self

9 BIRTHPLACE (city or town) Gloucester Co.

(State or country) Va

PARENTS

10 NAME OF FATHER John R Cutchin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Emeline M Hobday

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs Cora N. Cutchin

(Address) 3936 Norfolk Ave.

15 Filed , 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 19 1930.

17

I HEREBY CERTIFY, That I attended deceased from Feb 16, 1930, to Feb 19, 1930, that I last saw him alive on Feb 19, 1930, and that death occurred, on the date stated above, at 6.40 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? +

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Necropsy

(Signed) W Kerr Williams, M. D.

, 19 (Address) 3201 Sequoia Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Feb 22 1930

20 UNDERTAKER Wm J Tuckwell Sons ADDRESS North Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 54273

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 54273

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 N. Bethel ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucinda Waters

(a) RESIDENCE NO. 611 N. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Waters

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Selbyville Del

PARENTS

10 NAME OF FATHER Wring Showell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John Waters

(Address) 611 N. Bethel st

15 Filed FEB 21 1930, 19 HAMDEN JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 18/30

17 I HEREBY CERTIFY, that I attended deceased from Feb 18, 1930, to Feb 18, 1930, that I last saw h[illegible] alive on Feb 18, 1930 and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Acute Aspiration Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) no

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Sutherland, M. D.

19 (Address) 508 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL Feb 21 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

Important: See instructions

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54274

CERTIFICATE OF DEATH

90 ✓ E 54274

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Sinclair Lane ST., 17 WARD)

2—FULL NAME Albert E. Taylor

(a) RESIDENCE NO. 2011 Sinclair Lane ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

(If residence in city or town where death occurred) 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Sarah Taylor

6 DATE OF BIRTH (month, day, and year): Nov 20-1866

7 AGE: Years 63 | Months 3 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Samuel Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: Mrs. Rl

(Address) 2011 Sinclair Lane

15 Filed FEB 21 1930, 19 Rlt Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 19-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 19 30, to Feby 19, 19 30, that I last saw h alive on Feby 19, 19 30 and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallace W. White Jr., M. D.

, 19 (Address) 2800 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel

DATE OF BURIAL: Feb. 22 1930

20 UNDERTAKER: John H. Moran

ADDRESS: 3000 E. Balto

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54275

CERTIFICATE OF DEATH

4 | ✓ E 54275

REGISTERED NO.

1—PLACE OF DEATH Union Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 18-26 (WARD)

2—FULL NAME Margaret O'Meara

(a) RESIDENCE NO. 524 Arlington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec ? 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleswoman 067

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Stevens & Co.

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick O'meara

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Anna Donahue

13 BIRTHPLACE OF MOTHER (city or town) Md. Maryland
(State or country)

14 Informant Wm. Omeara

(Address) 524 Arlington Ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

2-1-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 19 1930

17 I HEREBY CERTIFY, That I attended deceased from February 18, 19 30, to February 19, 19 30, that I last saw h er alive on February 19, 19 30 and that death occurred, on the date stated above, at 1 25 P m.

The CAUSE OF DEATH* was as follows:

Fever of undetermined origin

(duration) ....yrs....mos....da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ....yrs....mos....da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Richard T. Shackelford, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mass Cathedral

DATE OF BURIAL Feb 22, 1930

20 UNDERTAKER John A. Morden

ADDRESS 3000 E Balto St.

Spec.—2-29-28—L. P. S.—500 Blks.

E 54276

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54276

CERTIFICATE OF DEATH

1—PLACE OF DEATH
CITY OF BALTIMORE. (No. South Baltimore Gen Hospital ST., WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary C. George

(a) RESIDENCE NO. 1514 E. Federal ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	widowed

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
71				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire

14 Informant Mrs J. M. Casey
(Address) 1514 E Federal St

15 Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19-30

17 I HEREBY CERTIFY, That I attended deceased from 2-14, 1930, to 2-19, 1930, that I last saw h.. alive on 2-19, 1930 and that death occurred, on the date stated above, at 5.18 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph B. Laukaitis, M. D.

19 (Address) South Balto. Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL Feb 22 1930

20 UNDERTAKER Rita Weisfeld

ADDRESS 914 Greenmount Ave

Spec.—1-30—M. & T.—250 Blks.

E 54277 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 54277

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Balto City Hosp. 5-8
CITY OF BALTIMORE: (NO. ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hall

(a) RESIDENCE NO. 1057 Fairmount Ave WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Unknown, How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frances Hall

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
62?		Unknown		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 0.0.
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer Unknown.

9 BIRTHPLACE (city or town) Unknown
(State or country) Md.

PARENTS
10 NAME OF FATHER James Hall
11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country) Md.
12 MAIDEN NAME OF MOTHER Hallie Brown
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Md.

14 Informant Balto City Hosp. Records
(Address)

15 Filed 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-16-30

17 I HEREBY CERTIFY, That I attended deceased from 12-31-, 1929, to 2-16-, 1930,
that I last saw him alive on 2-16-, 1930,
and that death occurred, on the date stated above, at 3 4 m.

The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(Pyloric end)
(duration) Unknown ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? yes Date of 1-13-30
Was there an autopsy? no
What test confirmed diagnosis? Exam at autopsy.
(Signed) Fred M. Rinkenbach, M. D.
, 19 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
UNIVERSITY OF MARYLAND 19

20 UNDERTAKER — ADDRESS
Commissioner Health FEB 21 1930

C. HAMPSON JONES, M. D.

PAT. APP'D. FOR. S. NOSSAM

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 54278

E 54278

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Chambers

(a) RESIDENCE NO. 2320 Boston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber 604

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed FEB 21 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-17-30

17 I HEREBY CERTIFY, That I attended deceased from 12-11-22, 19..., to 2-17-30, 19...,

that I last saw him alive on 2-17-30, 19...,

and that death occurred, on the date stated above, at 1:35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Warren M. McLean, M. D.

2-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS FEB 21 1930

FILM 6 RECORDED

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54279 E 54279

CERTIFICATE OF DEATH.

REGISTERED NO. 124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2014 Eagle St. 20-28 (WARD)

2-FULL NAME Vernon E. Byron

(a) RESIDENCE NO. 2014 Eagle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Son.

6 DATE OF BIRTH (month, day, and year): Feb 19 1910

7 AGE: Years 20 | Months | Days 1 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lecturer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Nicholas Byron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Maude Arnold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Maude Kahlenberg
(Address): 2014 Eagle St

15 Filed Feb 21 1930 Registrar: RUSK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 2 - 1930 to Feb 19 1930.
that I last saw him alive on Feb 19 1930
and that death occurred, on the date stated above, at 5.15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Nephritis
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Estelle Hemmeter, M. D.

2/21 1930 (Address) 2001 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: Feb 24 1930

20 UNDERTAKER: John Fuld — ADDRESS: 1200 W Lombard

C. HAMPSON JONES, M. D.

TION is very important See instructions on back of

Spec.—2-29-36—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54280

CERTIFICATE OF DEATH

90 E 54280

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 N. Broadway ST. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nickolaus Wolfsmant

(a) RESIDENCE NO. 805 N. Broadway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 5 mos. 9 ds. How long in U. S., If foreign birth? 8 yrs. 5 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Wolfsman

6 DATE OF BIRTH (month, day, and year) Oct 31, 1843

7 AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
86	4	19	18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) Seehausen
(State or country) Germany

PARENTS

10 NAME OF FATHER Lue Wolfsman

11 BIRTHPLACE OF FATHER (city or town) Seehausen
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Seehausen
(State or country) Germany

14 Informant Mrs Emma Monberger
(Address) 805 N. Broadway

15 Filed ___, 19 ___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19/1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929 to Feb 19, 1930

that I last saw h[illegible] alive on Feb 19, 1930

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Cabinet Maker Heart Disease

5
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis
(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John D. Gold M. D.

Feb 21, 1930 (Address) 936 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Immanuel

DATE OF BURIAL 2/23 1930

20 UNDERTAKER Louis Heemann

ADDRESS 32 S Broadway

Spec.—1-12-29—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

E 54281

CERTIFICATE OF DEATH

90 E 54281

REGISTERED NO.

1-PLACE OF DEATH 2512 Brookfield ave

CITY OF BALTIMORE: (No. 1359 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Wohlmuth

(a) RESIDENCE NO. 2512 Brookfield ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Late Rosa

6 DATE OF BIRTH (month, day, and year) Jan 14 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Manufacturing

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Johan Wohlmuth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Frida —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Frank Waldman

(Address) 2512 Brookfield ave

15 Filed FEB 21 1930 Registrar

CHAMPION JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. , 1929 to Feb. 20, 1930,

that I last saw h im alive on Feb. 20, 1930

and that death occurred, on the date stated above, at 12.25 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

3

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & Lab.

(Signed) Isidore L. Levy, M. D.

Feb 1930 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 2/21/1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Baltimore St

TION is very important See instructions on back

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54282

CERTIFICATE OF DEATH.

90

E 54282

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1327 W. Lafayette av. (St.) 16-23 (WARD)

2-FULL NAME Eliza E. Howe.

(a) RESIDENCE NO. 1327 W. Lafayette av. (St.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Howe

6 DATE OF BIRTH (month, day, and year) Sept 15, 1867

7 AGE 62 Years 63 Months 5 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md.

PARENTS

10 NAME OF FATHER Robert Forester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Ethel Burley. (Address) 1327 W. Lafayette Ave

15 Filed FEB 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19 1930.

17 I HEREBY CERTIFY, That I attended deceased from 2/4, 1930, to 2/19, 1930, that I last saw h[illegible] alive on 2/19, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. V. Pyatt M. D.

2/20/30 (Address) 1536 W. Lafayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 2/22 1930

UNDERTAKER Thomas E. Kelson

ADDRESS 1803 Freeman St

TION is very important

Spec.—8-16-29—L. F. S.—100 Bks.

E 54283

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54283

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 6-9 WARD)

REGISTERED NO. 1/18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Louise Snyder

(a) RESIDENCE NO. 111 Linn St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilkens Snyder

6 DATE OF BIRTH (month, day, and year): 17 June—1866

7 AGE: Years 64 | Months 8 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jacob Scheerlitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Kreb

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Scheerlitz

(Address) 212 Ost Holly St

15 Filed 19 Registrar

Important. Use Instructions on Reverse Side.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 20, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1930, to Feb. 20, 1930,

that I last saw her alive on Feb. 20, 1930,

and that death occurred, on the date stated above, at 11:20 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction following strangulation inguinal hernia (left).

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological findings

(Signed) W. W. Elgin, M. D.

2/20, 1930 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park | DATE OF BURIAL: Feb 24 1930

20 UNDERTAKER: Josiah Lefler | ADDRESS: 1600 W Baltimore

C. HARRISON JONES, M. D.

2/21/1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 54284

E 54284

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2701 Allendale Road (ST.) 15-6 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Victoria Cox Howes

(a) RESIDENCE NO. 2701 Allendale Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel W. Howes

6 DATE OF BIRTH (month, day, and year) Aug. 30 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER James N. Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Wm M. Graham

(Address) 2701 Allendale Road

15 Filed 2-21 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 20-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, 1929, to Feb 20, 1930, that I last saw her alive on Feb 20 1930 and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? +

Did an operation precede death? no Date of +

Was there an autopsy? no

What test confirmed diagnosis? Paralysis ?

(Signed) W. Kerr Russell, M. D.

19 (Address) 3200 Sequoia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

20 UNDERTAKER Harry W. Ehlen

DATE OF BURIAL Feby 22 1930

ADDRESS 1901 W. North Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 54285

E 54285

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Booth ST. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mark Travers

(a) RESIDENCE NO. 1025 Booth ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX— M

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Mar

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ [illegible]

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John Travers Sr

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mark Travers Jr

(Address) 1024 Booth St

15 Filed [illegible] Registrar

B21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1929, to Feb. 20, 1930, that I last saw h alive on Feb 20, 1930 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F Norwood, M. D.

Feb 21, 1930 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 2-23 1930

20 UNDERTAKER Wm H. Chase Son

ADDRESS 1400 Mosher

Important. See instructions on the back

Spec.—1-10-21—M&T—1500 Bks.

E 54286

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 54286

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland) ST., 5-40 WARD)

2-FULL NAME Mrs. Vera Waddy

(a) RESIDENCE NO. 2210 - Loney Lane ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 28. 1898

7 AGE — Years: 31 — Months: 10 — Days: 22 — If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED — (a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Alexander Waddy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER Bertha Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Melvin Jordan

(Address) 2312 E. Chase St.

Filed FEB 21 1930

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/19, 1930, to 2/19, 1930, that I last saw her alive on 2/19, 1930, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhage.

(duration) ..... yrs. ..... mos. ? ds.

CONTRIBUTORY (Secondary) Syphilis of the Stomach

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? None —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Path. and Gen. Autopsy.

(Signed) A. S. Gray, M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: 3/2/30

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 Ireland St.

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 54287

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE. (No. 1715 Chilton St. 13 Ward) 106

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emilius Miller

(a) Residence No. 2318 Boston St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-(Single, Married, Widowed or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of deceased May B. Miller

6-DATE OF BIRTH (month, day and year) 2.29.1852

7-AGE. 77 yrs. 11 mos. 20 ds. If LESS than 1 day, hrs. or min.? 21

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Harness Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self Empl.

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant) Mrs. Cora Schwartz

(Address) 1715 Chilton St.

15-Filed 1-1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2.20.30

I HEREBY CERTIFY, That I attended deceased from November 29 1929 to Feb. 20 1930

that I last saw h. alive on Feb. 20 1930

and that death occurred, on the date stated above, at 4-15 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Hales H. A. Meyer M. D.

2/20, 1930 (Address) 1032 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem.

DATE OF BURIAL, Feb. 24, 1930

20-UNDERTAKER. Henry Sander & Sons. Inc

ADDRESS Baltimore St. & Broadway.

instructions on back of certificate.

2

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54288

CERTIFICATE OF DEATH

E 54288

REGISTERED NO. 100

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 Bank ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ANNA C. KAHL

(a) RESIDENCE NO. 1807 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Kahl

6 DATE OF BIRTH (month, day, and year) June 17, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Albert Seifert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Edward Kahl (Son)

(Address) 1807 Bank Street

15 Filed 2 1930, 19 C. HAMPSON JAMES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19/30, to Feb. 19, 1930, that I last saw her alive on Feb 19-30, and that death occurred, on the date stated above, at 11.40 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Gangrene - left leg

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Herrman, M. D.

2/21, 19 30 (Address) 2912 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Feb. 23 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS Baltimore St. & Broadway.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54289 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54289

3 1/2

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T. B.) REGISTERED NO. 27-30

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Simms

(a) RESIDENCE NO. 625 W. Barre st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 240

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Tom Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Margaret Sumpton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address)

Filed 1930 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1929, to Feb. 16, 1930, that I last saw him alive on Feb. 16, 1930 and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Abscess of liver

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Thos Thornald Jr. M. D.

2-16-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	2/20 1930
20 UNDERTAKER Samuel L. Buckley	ADDRESS 1700 E. Balto

Spec.—8-16-29—L. F. S.—100 Bks.

E 54290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓ E 54290

REGISTERED NO. 24-33

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 E. Ostend St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A. Evans

(a) RESIDENCE NO. 127 E. Ostend St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pryor A. Skidmore

6 DATE OF BIRTH (month, day, and year) Dec. 4 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John A. Evans

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Farrel

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Evans
(Address) 127 E. Ostend St

15 Filed 2 1 1930

16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1930, to Feb. 20, 1930

that I last saw him alive on Feb. 20, 1930

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

2/21, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Feb 24 1930

20 UNDERTAKER D. Fenw McCully

ADDRESS 1306 Fort

Spec.—1-12-23—M&T—500 Blks.

E 54291

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54291

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~1145~~ 1145 Ridgley St. 31-A WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hedrick Weinaechter

(a) RESIDENCE NO. Dorsey Md. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Weinaechter

6 DATE OF BIRTH (month, day, and year) Dec 19th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min
	56	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl C. Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Hausmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Johanna Berg (Neice)

(Address) 1145 Ridgley st

Filed 2 1 1930 C. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2.20.30.

17 I HEREBY CERTIFY, That I attended deceased from 11.11.30, 19..., to 2.20.30., 19..., that I last saw h[illegible] alive on 2.2.30., 19..., and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dorsey Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chimical-Microscop.

(Signed) Philip B. Fowler, M. D.

2.20.30. 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Cem. Dorsey Md

20 UNDERTAKER E. Schloman & Son

DATE OF BURIAL Feb 22nd 1930

ADDRESS 1089 Bmore

8 TION is very important. See instructions

Cor.—10-10-29—A Co.—100 Bks.

E 54292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 2025 ✓ 54292

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital 2500 St., 7-9 Ward)

2-FULL NAME Washington Cannon

(a) RESIDENCE NO. 164 1st St. Eastport, Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 hrs (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith May Lillian Cannon

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Police Ice Plant
(c) Name of employer U. S. Naval Acade

9 BIRTHPLACE (city or town)
(State or country) A. A. Co., Md.

PARENTS

10 NAME OF FATHER Washington Cannon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) A.A. CO., Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant John M. Taylor
(Address) Annapolis, Md.

15 Filed 2 1 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Purulent Meningitis- Accidently struck by steel bar at work at Academy three weeks ago. Fractured Skull (duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death? U.S.Academy
Did an operation precede death? Date of
Was there an autopsy? At Hopkins
What test confirmed diagnosis? Autopsy

(Signed) [signature], M. D.
2/21/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md

DATE OF BURIAL Feb 21 1930

20 UNDERTAKER Jas. T. Taylor Sons

ADDRESS Annapol

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54293

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54293

CERTIFICATE OF DEATH

REGISTERED NO. 45

1—PLACE OF DEATH Army Memorial Hosp. 33rd & Calvert Sts

CITY OF BALTIMORE: (No. ST. 12-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr Louis C. Lehr.

(a) RESIDENCE NO. Hay Adams House ST. WARD

(Usual place of abode) Washington D. C.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor M. Lehr

6 DATE OF BIRTH (month, day, and year) Feb 7, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Surgeon

(b) General nature of indostry, business, or establishment in which employed (or employer) U. S. 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert Lehr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hannover Germany

12 MAIDEN NAME OF MOTHER Mary Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wheeling W. Va.

14 Informant Hospital Records.

(Address)

15 Filed 2 1 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1929 to Feb 20, 1930, that I last saw h[illegible] alive on Feb 20, 1930 and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows: Retroperitoneal Sarcoma

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington D. C.

Did an operation precede death? yes Date of Dec 24, 1929

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms.

(Signed) Frances W. Slack M. D.

2/20, 1930 (Address) U. M. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Feb 22, 1930

20 UNDERTAKER Geo. J. Jenkins Sons Co.

ADDRESS Eutaw & Mt. Royal Ave

Spec.—1-12-23—M&T—500 Blks.

E 54294

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2301 E. North Ave

CITY OF BALTIMORE: (NO. ..... ST., 8-16 WARD)

REGISTERED NO. 16 E 54294

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Schnabel

(a) RESIDENCE NO. 2301 E North Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John M. Schnabel

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Baker

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant John M. Schnabel
(Address) 2301 E. North Ave.

15 Filed 2-21-1930 G. HAMPSON JONES, M. D. Registrar
By AKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/11/30, 19..... to Feb 21, 19 30,
that I last saw h[illegible] alive on Feb. 20, 19 30,
and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Premature delivery (7 month pregnancy)

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) L. Schnabel, M. D.

2/21, 1930 (Address) 447 N. Linwood ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb 22nd 1930

20 UNDERTAKER Leo S. Cook — ADDRESS 1723 Patt Pk ave

TION is very important. See instructions on back of

Spec.—1-12-23—M&T—500 Blks.

E 54295

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54295

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2205 Etting (St.) 14-59 (Ward)

2-FULL NAME Ernest Rice

(a) RESIDENCE NO. 2205 Etting ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27, 1912

7 AGE: Years 18 Months 6 Days 21

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va Charlotte Co

PARENTS

10 NAME OF FATHER Edward Rice.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Elizabeth Spencer 2205 Etting St.

15 Filed 2 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 14 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1930 to Feb 14 1930

that I last saw him alive on Feb 8 1930

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) 8 mos. ..... da.

CONTRIBUTORY (Secondary) Poor Nutrition

(duration) ..... yrs. ..... mos. 11 da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) W. F. Coleman M. D.

2 1930 (Address) 2239 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary cemetery

DATE OF BURIAL: 2/22 1930

20 UNDERTAKER: Thomas E Kelson

ADDRESS: 1803 Pennsylvania Ave

TION IS very important

Spec.—1-10 21—M&T—1500 Blks.

E 54296

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54296

CERTIFICATE OF DEATH.

100-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 651 Lumbarton ave St.) (9-47 WARD)

2-FULL NAME Mollie E. Greer

(a) RESIDENCE NO. 651 Lumbarton ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced H[illegible] of (or) WIFE of Wm J Greer

6 DATE OF BIRTH (month, day, and year) April 26 1865

7 AGE — Years: 64 Months: 9 11 Days: 25 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER George Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Catherine Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md Maryland

14 Informant: Mrs Kurt Hagan

(Address) 651 Lumbarton ave

15 Filed 2 1 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930, to Feb 20, 1930, that I last saw her alive on February 20, 1930, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. C. Brantom, M. D.

, 19 (Address) 5 E Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feb 1930

20 UNDERTAKER: Henry Lutz — ADDRESS 1203 N. Broadway

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54297

CERTIFICATE OF DEATH

91-002 E 51297

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Mc Guire

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thomas Mc Guire

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Finley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley Sts

15 FEB 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930 to Feb 20, 1930

that I last saw h' alive on Feb 20, 1930

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Senility
Arteriosclerosis

(duration) ....yrs....mos....da.

CONTRIBUTORY
(Secondary)

(duration) ....yrs....mos....da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

2/21/30 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL Feb 22 1930

20 UNDERTAKER Rita Mudefield — ADDRESS 47 Grumet Ave

Spec.—1-12-23—M&T—500 Blks.

WOLFENDEN

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54298

CERTIFICATE OF DEATH.

61-09 E 54298

REGISTERED NO. 27-54

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5706 Falls Road ST. (or WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of James Allan Wolfenden

(a) RESIDENCE NO. 5706 Falls Road ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of V

6 DATE OF BIRTH (month, day, and year) Feb. 21-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work V

(b) General nature of industry, business, or establishment in which employed (or employer) V

(c) Name of employer V

9 BIRTHPLACE (city or town) 5706 Falls Road

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Allan Wolfenden

11 BIRTHPLACE OF FATHER (city or town) Washington

(State or country) D.C.

12 MAIDEN NAME OF MOTHER Eliza E. Pierce

13 BIRTHPLACE OF MOTHER (city or town) Frederick Md

(State or country)

14 Informant James Allan Wolfenden

(Address) 5706 Falls Road

15 Filed 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1930

17 I HEREBY CERTIFY, That I attended deceased from July 21, 19.., to July 21, 1930, that I last saw h.. alive on July 21, 1930, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth (6mo gestation)

(duration) 2 yrs. mos. 15 min da.

CONTRIBUTORY (Secondary) Mothers Influenza (4 days)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? V Date of

Was there an autopsy? V

What test confirmed diagnosis? V

(Signed) Thomas C. Jones, M. D.

, 19 (Address) 7717 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) DATE OF BURIAL Feb. 22, 1930.

20 UNDERTAKER Horace P. Burgee ADDRESS 363 Falls Road

TION is very important. See instructions.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54299

CERTIFICATE OF DEATH

101 1-09

E 54299

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 403 Pearl St. 17-25 Ward)

2-FULL NAME James E. Woodson

(a) RESIDENCE NO. 403 Pearl St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1- 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3		19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Louis Woodson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Lee

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Elizabeth Woodson
(Address) 403 Pearl St

15 Filed 2-21 19 30 C. HAMPSON JONES, M. D. Registrar
By APW

OF DEATH in plain ctrs, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

2/21, 1930 (Address) 2709 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 2/24 1930

20 UNDERTAKER David Easton

ADDRESS 916 Penna Ave

Spec.—1-30—M. & T.—250 Blks.

E 54300 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 51300

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 Poplar Grove St., 16-68 WARD)

2-FULL NAME Amelia E. Mosser

(a) RESIDENCE NO. 1223 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Daniel A. Mosser

6 DATE OF BIRTH (month, day, and year) Oct 15-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Benjamin Barto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Iva B Mosser

(Address) 1223 Poplar Grove

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21/30

17 I HEREBY CERTIFY, That I attended deceased from 3/7/30, 19..... to 3/21/30, 19.....

that I last saw h alive on 3/20/30, 19.....

and that death occurred, on the date stated above, at 1.55 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 2 yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gray, M. D.

3/21/30 (Address) 827 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reading Penna

DATE OF BURIAL 3/21/1930

20 UNDERTAKER William Cook

ADDRESS 1217 Shut

C. PAMPSON JONES, M.

2 1 1930

Spec.—1-30—M. & T.—250 Bks.

E 54301 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

Buried Feb 22 1930

90 Feb 22 66

CERTIFICATE OF DEATH.

REGISTERED NO. E 54301

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2030 N. Wolfe ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Lind

(a) RESIDENCE NO. 2030 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Simond Lind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Haisty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward Lind

(Address) 2030 N. Wolfe St.

15 Filed ....., 19 .... Registrar

C. HAMPSON JONES, M.D.

3 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1930, to Feb 20, 1930, that I last saw h— alive on Feb 20, 1930, and that death occurred, on the date stated above, at 7 P— m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Renal

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Burke Grant, M. D.

, 19 (Address) 125 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Feb. 22 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul

Spec.—1-30—M. & T.—250 Bks.

Helen
2657 N North Ave

E 54302 HEALTH DEPARTMENT—CITY OF BALTIMORE 3/ E 54302

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3204 Baker St. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel M. Foltz

(a) RESIDENCE NO. 3204 Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Foltz

6 DATE OF BIRTH (month, day, and year) Feb 17-1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elwood Wilkerson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisianna

12 MAIDEN NAME OF MOTHER Amanda Gust

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant W. Wilderson (Address) 3204 Baker St

15 Filed 2 11 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1922, to Feb 21, 1930, that I last saw h.t.w. alive on Feb 20, 1930, and that death occurred, on the date stated above, at 8 AM.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage & Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Walker, M. D.

2/21/30 (Address) 27 W. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 2/24 1930

20 UNDERTAKER W. Cook

ADDRESS 1217 St Paul

Spec.—8-16-29—L. F. S.—100 Bks.

E 54303

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54303

CERTIFICATE OF DEATH

122 - 002

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2231 Barclay ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Marian Brucup

(a) RESIDENCE NO. 2231 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed-

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of John Olivier Brucup

6 DATE OF BIRTH (month, day, and year) Feb 15-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	mo	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Dorchester Co. (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Henry Davis

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co. (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Cornelia Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co. (State or country) Maryland.

14 Informant Mary C. Travers.

(Address) Blymyer Hall apts.

15 Filed FEB 21 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 20-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 28- 1929, to February 21- 1930, that I last saw h[illegible] alive on February 20- 1930 and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of Liver

(duration) unknown. yrs. mos. ds.

CONTRIBUTORY (Secondary) none (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical Signs & Symptoms

(Signed) Chester Ruland, M. D.

2-21-1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 2/22 1930

20 UNDERTAKER Williams Co

ADDRESS 12 St Paul

Spec.—1-10-21—M&T—1500 Blks.

E 54304 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54304

+43

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 25-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Henry Crawford

(a) RESIDENCE NO. Fairhope, Ala, ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. mos. 12 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of H. Crawford

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	51 yr			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 04

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ala,

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Louise T. Crawford (Address) Fairhope Ala

15 2 2 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-10-30, 19, to 2-22-30, 19,

that I last saw him alive on 2-22-30, 19,

and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mammary gland

(duration) Indefinite mos ..... ds.

CONTRIBUTORY (Secondary) P.O. Sinus

(duration) ..... yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 2-13-30

Was there an autopsy? No.

What test confirmed diagnosis? Biopsy Section

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fair Hope alabama — DATE OF BURIAL July 22 1930

20 UNDERTAKER Robert Brookshire — ADDRESS Calhoun Hollins

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54305

CERTIFICATE OF DEATH

90 E 54305

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 548 W Hoffman St. 17-24 Ward)

2-FULL NAME Walter Roberts

(a) RESIDENCE NO. 548 W Hoffman St., Ward

(Usual place of abode). (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert Roberts

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Clark

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mrs Mitchell
(Address) 567 Hoffman

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

3 22 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) Feb 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Regular

(Signed) H. Leibush M. D.

Feb 20th 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 2-23 1930

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Edmondson

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54306

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54306

CERTIFICATE OF DEATH

REGISTERED NO. 5

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3022 Clifton park ter ST. Ward 5)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Miller

(a) RESIDENCE NO. 3022 Clifton Park terrace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if foreign birth? 62 yrs. 6 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leo. R. Miller

6 DATE OF BIRTH (month, day, and year) July 28 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
62	61	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore city Maryland

PARENTS

10 NAME OF FATHER John Steinmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER not Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Leo. R. Miller (Address) 3022 Clifton Park terrace

15 Filed 2 22 1930 C. HAMPSON JONES, M. D. Registrar By AAB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1930, to Feb 21, 1930, that I last saw h alive on Feb 21, 1930, and that death occurred, on the date stated above, at 4 45 p.m.

The CAUSE OF DEATH* was as follows: Cirrhosis of Liver with Ascites (Chronic)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic Absorption

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Kent, M. D.

Feb. 22, 1930 (Address) 4403 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb 24 1930

20 UNDERTAKER August Tasch ADDRESS 2406 Eastern ave

Important. See instructions on

Spec.—1-12-23—M&T—500 Bks.

E 54307

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54307

CERTIFICATE OF DEATH.

REGISTERED NO. 429

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 208 N. Bruce St. (ST.) (WARD) 19-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Clements

(a) RESIDENCE NO. 208 N. Bruce St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
Abt. 60				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Prince Geo. Co. Md.

PARENTS

10 NAME OF FATHER John CLements

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ellen Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Geo. Co. Md.

14 Informant Bessie Brown (Address) 208 N Bruce St.

Filed 2 2 1930, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/19 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1930, to Feb. 19, 1930.

that I last saw h e alive on Feb. 19, 1930

and that death occurred, on the date stated above, at 7:30 a.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL Feb. 22, 1930

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 322 N. Schroeder St

TION is very important. See instructions

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54308 001 E 54308

CERTIFICATE OF DEATH

REGISTERED NO. 24

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adalbert Wiatrowski

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6th 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jacob Wiatrowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Valley Sts

Filed FEB 22 1930 19 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1930, to Feb 20, 1930, that I last saw h... alive on Feb 20, 1930 and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ...yrs. ...mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Bernstein, M. D.

2/21, 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery

DATE OF BURIAL: Feb 24 1930

20 UNDERTAKER: George A. Weber

ADDRESS: 705 Lanvale St

Spec.—1-10 21—M&T—1500 Bks.

E 54309 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54309

58-001 7

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 Division St WARD)

2-FULL NAME Elizabeth Dorsey

(a) RESIDENCE NO. 2219 Division St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 46; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Annie Roberts

(Address): 2219 Division St

15 Filed: 3 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9th, 1930, to Feb 19th, 1930.

that I last saw her alive on Feb 19th, 1930,

and that death occurred, on the date stated above, at 10.15 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) Geo. H. Langenbacher M. D.

2-19, 1930 (Address) 2218 St Paul Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 2-22, 1930

20 UNDERTAKER: Daniel Easter & Co

ADDRESS 916

CAUSE OF DEATH TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54310 E 54310

CERTIFICATE OF DEATH.

REGISTERED NO. T

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Carlton & Oliver St. 24-33 Ward

(If death occurred in a hospital or institution give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Elliott

(a) RESIDENCE NO. 1307 Webster St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Elliott

6 DATE OF BIRTH (month, day, and year): March 7, 1892

7 AGE: Years 37 Months 11 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Timothy J. Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Catherine L. Imhoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant (Address): Harry Elliott 1307 Webster St

15 Filed Feb 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14 1930 to Feb. 21 1930, that I last saw her alive on Feb. 21 1930, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Salpingitis

Appendicitis (secondary)

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Paralytic Ileus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Feb. 14, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Vincent Messina M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: Feb 24 1930

20 UNDERTAKER: A. Howard Evans

ADDRESS: 38 S Paca

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54311 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 100-001 E 54311

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 107 W. Randall (Ward) 23-32

2-FULL NAME Violet E. Marshall.

(a) RESIDENCE NO. 107 W. Randell ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 0 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) June, 7, 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	/	8.	4. 14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Oris H. Marshall.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mt. Jackson Va.

12 MAIDEN NAME OF MOTHER Mary F. Thomas.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Oris H. Marshall
(Address) 107 W. Randall.

Filed 3 22 1930. 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1930, to Feb. 21, 1930, that I last saw her alive on Feb. 21, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) 0 yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. H. Campbell M. D.

2/24 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Feb 22 1930

20 UNDERTAKER D. A. Howard Evans & E. Fortney — ADDRESS

Spec.—1-10-21—M&T—1500 Blks.

E 54312

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54312

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH St. Agnes Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caton & Wilkens Aves ST. 12-49 (WARD)

2-FULL NAME Mary McLaughlen

(a) RESIDENCE NO. University Apt 5-B City ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Phillip McLaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Lilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant niece (Mrs C. Reynolds) (Address) 12 Club Rd Roland Park

15 FILED FEB 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21 — 1930

17 I HEREBY CERTIFY, That I attended deceased from 5-17 .1929. to 2-21 — .1930.

that I last saw her alive on 2-21 — .1930.

and that death occurred, on the date stated above, at 2.30 a .m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 10/22/29

Was there an autopsy? no

What test confirmed diagnosis? Frozen section

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Feb 24 1930

20 UNDERTAKER John O Mitchell Sons

ADDRESS 1900 Eutaw Place

CAUSE OF DEATH. See instructions on back of certificate. ATTENTION is very important.

Spec.—1-30—M. & T.—250 Blks.

Dr Crowden 1517 E. North Ave
Ver 1653

E 54313

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 E 54313

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1214 N. Bond ST. (Ward) 8-13

2-FULL NAME Georgiana Elsworth

(a) RESIDENCE NO. 1214 N. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, ~~or divorced~~
~~HUSBAND~~ of
(or) WIFE of David Elsworth

6 DATE OF BIRTH (month, day, and year) 6/12/1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Crisp

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kirby

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mabel Elsworth
(Address) 3002 Brady Ave

Filed 2-2-1930, 19.. C. HAMPSON JONES, M. D.
By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20/30

17 I HEREBY CERTIFY, That I attended deceased from 2/15/30, 19.., to 2/20/, 1930,
that I last saw h.. alive on 2/19/, 1930,
and that death occurred, on the date stated above, at 5.10 — m.

The CAUSE OF DEATH* was as follows:

Bronchs- pneumonia-

(duration) .. yrs. .. mos 5 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) .. yrs. .. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ..

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) George abner Crowden, M. D.

2/2, 1930 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 2/22/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

E 54314

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 54314

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 25-37

CITY OF BALTIMORE: (No. 2258 Cedley ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Doris Estelle Lukas

(a) RESIDENCE NO. 2258 Cedley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feby. 20. 1930

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): add

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Chas Lukas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Hadya Schemer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Chas Lukas

(Address): 2258 Cedley st

15 FILED: 2 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/22/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1930, to Feb. 22, 1930, that I last saw her alive on Feb. 21, 1930 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Anthony V. Bikkuses, M. D.

19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Feby 23 1930

20 UNDERTAKER: [illegible]

ADDRESS: 200 Baker

Important: See instructions on reverse side.

Spec.—1-10-21—M&T—1500 Bks.

E 54315 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-00 54315

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 S. Sharp St) 23-3rd

2-FULL NAME James Ford

(a) RESIDENCE NO. 1018 S. Sharp St ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 27 - 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Ford

11 BIRTHPLACE OF FATHER (city or town) St. Vicent (State or country) Brg West Indians

12 MAIDEN NAME OF MOTHER Sadie Williams

13 BIRTHPLACE OF MOTHER (city or town) Cuba (State or country)

14 Informant Sadie Taylor
(Address) 1018 S. Sharp St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 21, 1930, that I last saw h[illegible] alive on Feb 20, 1930, and that death occurred, on the date stated above, at 5 H 5 A, m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) As Sthenia

(duration) yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) C. H. Jones M. D.

Feb 21 1930 (Address) 712 S Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemty

DATE OF BURIAL Feb 23 1930

UNDERTAKER Walter B. Spriggs

ADDRESS 2211 Pamlico St.

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificates. TION is very important.

B 2 2 1930

Spec.—1-10-21 M&T 1500 Bks.

E 51316 HEALTH DEPARTMENT—CITY OF BALTIMORE E 51316

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 N. Eden St ST. 5-8 WARD)

2-FULL NAME Hattie L. Gaines

(a) RESIDENCE NO. 720 N. Eden St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Gaines

6 DATE OF BIRTH (month, day, and year) Oct 15 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Sarah Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Eddie Thornton Smith

(Address) 720 N Eden St

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-22 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Feb 21, 1930, that I last saw her alive on Feb 21, 1930, and that death occurred, on the date stated above, at 8:00 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hamilton M. D.

2/22, 1930 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harmony Washington DC — DATE OF BURIAL Feb 24 1930

20 UNDERTAKER J. L. Brown & Son — ADDRESS 1019 N. Mt St.

CAUSE OF DEATH in plain terms, so that a layman can understand. See instructions on back of certificates.
TION is very important.

3 2 2 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 54317

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54317

CERTIFICATE OF DEATH

REGISTERED NO. 1124

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 Fleet St. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stefania Kisielewska

(a) RESIDENCE NO. 1822 Fleet St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Xawery Kisielewski

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Pete Malanowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Radziminski
(Address) 1822 Fleet St

15 Filed 3 22 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 20th, 1930, to Feb 20th, 1930, that I last saw h[illegible] alive on [illegible], 1930 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wisman, M. D.

2-22, 1930 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Feb 24 1930

20 UNDERTAKER H W Ozazewski 1930 Eastern Ave

Important. See instructions on back

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 199 E 54316

1-PLACE OF DEATH

City of BALTIMORE: (No. Patterson Park Av & Biddle St., Ward 8 1 2)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore F. Kratzer

(a) RESIDENCE NO. 2427 E. Biddle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud J. Kratzer

6 DATE OF BIRTH (month, day, and year) 6-12-1896

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	39 yrs.	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) In Business for self.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER George M. Kratzer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary C. Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Maud J. Kratzer

(Address) 2427 E. Biddle St.

15 Filed C. HAMPSON JONES, M. D.

2 2 1930 By NAH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & run down by a car & run down not apprehended Fract Skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Crushed Chest

(duration) yrs. mos. ds.

(Signed) G. J. Fraunfelder M. D.

(Coroner)

2/21 1930 (Address) 2939 N. Eldeley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Patterson P. K. & Biddle St.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer Cemetery Date of Burial Feb 23 1930

20 UNDERTAKER Elmer W. Conklin ADDRESS 924 E. Eager St.

OF DEATH in plain language, very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 54319

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54319

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 612. E Clement ST. 24th WARD 33

2—FULL NAME Marie Catherine Brown

(a) RESIDENCE NO. 612. E. Clement ST., 24th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): School girl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2-1917.

7 AGE: Years 12. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER Reuben A. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER Minnie Rdel..

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Minnie Brown.

(Address) 612. E. Clement st.

15 C. HAMPSON JONES, M. D. Registrar

FEB 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 8 1930 to Feb 21 1930

that I last saw h[illegible] alive on Feb 21 1930

and that death occurred, on the date stated above, at 6:30 A M

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary) Lou[illegible], Myocarditis

Nephritis (duration) yrs. mos. 10 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

2/24 1930 (Address) 6 Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Feb 24 1930

20 UNDERTAKER: Fred A. Kemerson — ADDRESS: 703 Monument st

Spec. 8-16-29 L. P. S.—100 Blks.

E 54320

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54320

CERTIFICATE OF DEATH

REGISTERED NO. 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 N. Hamburg ST. 21-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Ollie A. Brooks.

(a) RESIDENCE NO. 517 N. Hamburg ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23rd 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. Dept

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm. Brooks.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna Steuss.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Anna Yvonne

(Address) 517 W. Hamburg St

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

2 1930 By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/20/30

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to Feb 20, 1930

that I last saw h... alive on Feb 19, 1930

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonary

(duration) ... yrs. 8 mos. ... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) ... M. D.

2/24 1930 (Address) 517 Arch St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Feb 24 1930

20 UNDERTAKER Fred A. Richardson

ADDRESS 703 Hanover

Important: See instructions on reverse side.

Form.—8-16-29—L. F. S.—100 Blks.

2133989
54321

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 49 E 54321

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. Lee

(a) RESIDENCE NO. Kingsport – Tenn ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hazel Smalley Lee

6 DATE OF BIRTH (month, day, and year) Aug 29 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Division Supt. East

(b) General nature of industry, business, or establishment in which employed (or employer) Nan Rodak Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Parents

(Address) [illegible]

15 Filed ... 19 ... Registrar

C. HAMPSON JONES, M. D.

2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 19, 1930, to Feb 22, 1930, that I last saw ~~him~~ her alive on Feb 22, 1930 and that death occurred, on the date stated above, at 10:20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Lungs

(duration) yrs. 2 mos. ... da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. ... mos. 4 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? genual & Lab. Report

(Signed) R. Hampson Lund, M. D.

Feb 22 30 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Vernon Ohio

DATE OF BURIAL Feb 22 1930

20 UNDERTAKER John A. Mitchell & Sons

ADDRESS 1900 Eutaw St.

Spec.—8-16-29—L. F. S.—100 Bks.

54322

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54322 + 31 E 54322

CERTIFICATE OF DEATH

1—PLACE OF DEATH Church Home & Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. Broadway & Fairmount ST. East WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Alice Barth

(a) RESIDENCE NO. Woodbine, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced (or) WIFE of David Barth

6 DATE OF BIRTH (month, day, and year) 11-29-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(r) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Thos. Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Laura Oswald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant David Barth.

(Address) Woodbine, Md.

15 Filed Feb 28 1930 Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 21, 1930, that I last saw her alive on Feb 21, 1930 and that death occurred, on the date stated above, at 9 40 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary tbc

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Woodbine Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none.

(Signed) A. J. E. Abelcates, M. D.

, 19 (Address) Church Home Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co. Hemings Chapel Cemetery DATE OF BURIAL Feby 24th 1930

20 UNDERTAKER C. M. Watts ADDRESS Highland Md.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54323

E 54323

CERTIFICATE OF DEATH

E 54323

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. (ST.) 22-5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Lillian J. Brown

(a) RESIDENCE NO. 3019 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 2 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Mr. L. J. Brown

6 DATE OF BIRTH (month, day, and year) Dec 7 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. M. Jenkins

11 BIRTHPLACE OF FATHER (city or town) Balt. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Heath

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hospital Record

(Address)

FEB 23 1930

C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1930, to Feb. 22, 1930, that I last saw her alive on Feb. 22, 1930, and that death occurred, on the date stated above, at 6:50 p. m.

The CAUSE OF DEATH* was as follows:

Post-Operative Adhesions

Arteriosclerosis

Chronic Nephritis

(duration) 3 yrs. (?) mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 2/14/30 Adhesions

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

2-24-30 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state the Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill Cem Towson

DATE OF BURIAL Feb 26 1930.

20 UNDERTAKER John Burns Sons

ADDRESS Towson

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54324

CERTIFICATE OF DEATH.

129 E 51324

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 430 N Edew ST. 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Diana Moody

(a) RESIDENCE NO. 430 N Edew ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Thomas Moody

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE: 78 Years 27 Months Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbott Co Md

PARENTS

10 NAME OF FATHER: James Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Anna M. Collins 430 N. Edew St

15 Filed 3 23 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1930, to Feb 20, 1930,

that I last saw h alive on Feb 19, 1930,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis and Pulmonary Edema (duration) 1 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. F. Uhrig, M. D.

2/21. 1930 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery — DATE OF BURIAL: Feb. 23 1930

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1725 Ashland Ave

CAUSE OF DEATH to plain terms. Name of disease alone is not sufficient. See instructions on back of certificates. TION is very important.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51325

CERTIFICATE OF DEATH.

100-901 E 51325

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1929 E. Biddle St. 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraldine Elizabeth Wright

(a) RESIDENCE No. 1929 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Carrington Wright

11 BIRTHPLACE OF FATHER (city or town) Appomattox
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Nannie Parker

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.
(State or country) Md.

14 Informant Carrington Wright
(Address) 1929 E. Biddle St.

Filed FEB 23 1930 H. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-18-, 1930, to 2-21-, 1930, that I last saw h[illegible] alive on 2-21, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical.

(Signed) William Lady Berry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary — DATE OF BURIAL Feb. 24th 1930

20 UNDERTAKER Mrs. P. A. Elliott — ADDRESS 1725 Aisquith

TION is very important See instructions on back of certificate

Spec.—1-30—M. & T.—250 Bks.

✓ E54326

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54326

CERTIFICATE OF DEATH.

REGISTERED NO. 24-001 E 54326

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 2019 Druid Hill Ave ST. 1-14-30 (DATE)

2-FULL NAME Jennie Johnson

(a) RESIDENCE NO. 2019 Druid Hill Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE: Years 78 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED: Housework
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Joseph Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nettie Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Emma Scott
(Address) 2019 Druid Hill Ave

15 Filed 2-3 1930 19 C. HAMPTON CONNOLLY, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1/20/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930 to 20 Jan. 1930, that I last saw h[illegible] alive on 20 Jan 1930, and that death occurred, on the date stated above, at 12-20 A m.

The CAUSE OF DEATH* was as follows: Apoplexy (cerebral)

CONTRIBUTORY (Secondary) Hemiplegia Paralysis (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Dallas Tex

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Hall M. D.

19 30 (Address) 2210 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 1/23 19 30

UNDERTAKER Samuel I. Hensley

ADDRESS Middle

Spec.—1-30—M. & T.—250 Blks.

Dr Carman Carolina & Lanvale sts ✓

E 54327 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 54327
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 1411 10 Homestead ST. 27-56 (WARD)

2-FULL NAME Mary L. Campfield

(a) RESIDENCE NO. 8 W. Woodland Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Late Louis W. Campfield

6 DATE OF BIRTH (month, day, and year) 9/23/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	4	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) at Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS
10 NAME OF FATHER Bryan Thomas
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto
12 MAIDEN NAME OF MOTHER Lavinia Silence
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant C. M. Campfield
(Address) 1411 Homestead St

15 Filed 2-23-1930 G. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 21 —, 1930, to Feb 21, 1930,
that I last saw her alive on Feb 21, 1930,
and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:
Myocarditis, Acute Dilitation of Heart
Tymfanitis, & Emphysema

(duration) yrs. mos 1½ hr dys

CONTRIBUTORY (Secondary) Myocarditis & Hatulence a Cardiac (duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? 1411 Homestead St
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) R. H. Carman, M. D.
2-22-1930 (Address) 1705 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 2/24/1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

Spec.—1-30—M. & T.—250 Blks.

E 54328

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54328

31

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 N. Washington ST., 7-13 WARD)

2-FULL NAME Margaret Adle

(a) RESIDENCE NO. 922 N. Washington ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Henry A. Adle

6 DATE OF BIRTH (month, day, and year) 7/8/1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Kesselring

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Fannie Forrest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Henry Adle
(Address) 922 N. Washington St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/30

17 I HEREBY CERTIFY, That I attended deceased from 2-17-30, 19 29 to 2-22-30, 19 30, that I last saw h[illegible] alive on 2-22-30, 19 30, and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) 1 yrs. mo. da.

CONTRIBUTORY (Secondary) acute Nephritis

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Ned Smith M.D.

2-24-30 (Address) 1001 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cem — DATE OF BURIAL 2/25/1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

FEB 24 1930 S. HAMPTON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 54329

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54329

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Aisquith St ST. 5-8 WARD)

2-FULL NAME Lea Miller

(a) RESIDENCE NO. 114 Aisquith St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Miller

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. Miller (Address) 114 Aisquith St

15 Filed ..... 19 C. HARRISON JONES, M. D. Registrar

2-3 1930 RM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9th, 1930, to Feb. 23rd, 1930, that I last saw h[er] alive on Feb. 20th, 1930, and that death occurred, on the date stated above, at 12 05 a m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

Myocardial Degeneration

(duration) from yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam + Laboratory

(Signed) A. F. Rio, M. D.

, 19 (Address) 24 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Herring Rem

DATE OF BURIAL 2-3 1930

20 UNDERTAKER Jack Lewis 1439 E. Baltimore St

ADDRESS

Spcc.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54330

CERTIFICATE OF DEATH.

1 8 E 54330

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Rutland & Monument Sts. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Schaefer

(a) RESIDENCE NO. 29-N. Collington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Schoffer Heilemann.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ladies Tailor 8.0.

(b) General nature of industry, business, or establishment in which employed (or employer) Dresser

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Lena Kerber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Harry Kerber (Address) 3433 Parkhurst Ave

15 Filed FEB 23 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 6. 1930. to Feb 22. 1930. that I last saw h i alive on Feb 22. 1930. and that death occurred, on the date stated above, at 5:45 p. m.

The CAUSE OF DEATH* was as follows:

Esophageal Abscess, Acute

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Chr. Bronchitis & Emphysema

(duration) Many yrs. mos. da.

18 Where was disease contracted if not at place of death? Epinatic Service

Did an operation precede death? Yes Date of Feb-10.

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Benjamin Klotz M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 2/23 1930

20 UNDERTAKER Jack Louis 1439 E Baltimore

ADDRESS

CAUSE OF DEATH. See instructions on back of certificates. TION is very important.

Spec.—8-16-29—L. F. S.—100 Bks.

234196
E 54331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 54331

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. JOHNS HOPKINS HOSPITAL ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Goodman

(a) RESIDENCE NO. 147 S. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Goodman

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 67; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: unknown 67

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 23 1930, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 22-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930, to Feb 22, 1930, that I last saw h[illegible] alive on Feb 22, 1930 and that death occurred, on the date stated above, at 7 o 2 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia,

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X-ray chest.

(Signed) James Brady, M. D.

2/22, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 2/23 19 30

20 UNDERTAKER: Jack Levis

ADDRESS: 1439 E. Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103 ✓

E 54332

E 54332

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Balto G. Hosp. Ward 24-35

2-FULL NAME Raymond Grabowske

(a) RESIDENCE NO. 1446 S. Richardson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 2nd 1913

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	16	6	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Benny Grabowske

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Janina Nowak

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Benny Grabowske
(Address) 1446 Richardson

15 Filed 19 Registrar

EB 23 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows: Fell from rear of moving street car when he was pushing unknown to driver

Etc Fract Skull (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock (duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death In front of 520 Key Highway

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Fraser M. D.

2/23 1930 (Address) 2929 W. Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Feb 24 1930
20 UNDERTAKER John M. Weber & Wm. Coates	ADDRESS

OF DEATH in plain terms, so that it may be properly coded. All items are important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

234205 E 54333 100-001 E 54333

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gilbat Rominski

(a) RESIDENCE NO. 220 S Glover St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Rominski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Clorack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va

14 Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19

C. HAMPSON JONES, M. D. Registrar

B 23 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1930, to Feb. 21, 1930, that I last saw h[illegible] alive on Feb. 21, 1930 and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, broncho

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. O. G. Warson, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary cem

DATE OF BURIAL Feb. 24 1930

20 UNDERTAKER John M Weber and Chester

ADDRESS

Important: Use typewriter or ink.

Spec—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54334

E 54334

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 4-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sudie Allen

(a) RESIDENCE NO. 103 N. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Allen

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Griffin Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Adelia Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Record (Address)

15 Filed 2-23 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20-30

17 I HEREBY CERTIFY, That I attended deceased from 2-18, 1930, to 2-20, 1930, that I last saw h[illegible] alive on 2-20, 1930, and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma right breast

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lula Pumphrey, M. D.

2-21 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenville S. C.

DATE OF BURIAL Feb. 24th 30

20 UNDERTAKER Saml F. Chase Son

ADDRESS 400 Maker

Cor.—10-10-29—A Co.—100 Bks.

E 51335

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 102

E 51335

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No.) Hopkins Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calistine L. Vaughn

(a) RESIDENCE NO. Ruth Ave. Edgemere & Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Vaughn

6 DATE OF BIRTH (month, day, and year) July 27/1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Essex Co., Va.

PARENTS

10 NAME OF FATHER Wm. Thornton

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Saml W. Chase & Son
(Address) 1400 Mosher St

15 Filed E. HAMPTON JONES, M. D. Registrar

FEB 23 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cellulitis of neck (glands to mediastinum- Fibrous Pleurisy Bilat)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Drainind Sinus left maxillary (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins

What test confirmed diagnosis?

(Signed) E. K. Vaughn, M. D.

2/22/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Cem

DATE OF BURIAL 2-24-30

20 UNDERTAKER Saml W. Chase & Son

ADDRESS 1400 Mosher

OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

234095 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ 32

E 54336 **CERTIFICATE OF DEATH** E 54336

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 21-29 WARD)

2—FULL NAME Edgar Myers

(a) **RESIDENCE NO.** 327 Scott St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Friends —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 29 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1930, to Feb 20, 1930, that I last saw him alive on Feb 20, 1930 and that death occurred, on the date stated above, at 10 15P m.

The CAUSE OF DEATH* was as follows:
Pneumococcic meningitis.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 327 Scott St
Did an operation precede death? No Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy
(Signed) J W Bickford, M. D.
2/22, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 2/24/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Important: Use Indelible Ink

B 29 1930

Spec.—1-30—M. & T.—250 Blks.

Dr. C C Schmidt
Hanford Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54337

E 54337

REGISTERED NO. 24 E 54337

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3109 Westerna Ave St. Hamilton

2-FULL NAME Walter E Price

(a) RESIDENCE NO. 3109 Westeria Ave ST., Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie

6 DATE OF BIRTH (month, day, and year) Mar. 11-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Landscape Gardener.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Estelle M Price

(Address) 3109 Westeria Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Feb 22, 1930, that I last saw h[illegible] alive on Feb 22, 1930, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema
Cerebral Hemorrhage
Hemiplegia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clark Smith M. D.

Feb 22, 1930 (Address) 4 206 Hanford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Feb 24 1930

20 UNDERTAKER H M Cook — ADDRESS 1217 St Paul St

FROM THE [illegible] JOHNS HOPKINS [illegible]

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 54338

E 54338

REGISTERED NO.

1-PLACE OF DEATH 537 N. Lakewood Ave ST., 7-10 WARD)

CITY OF BALTIMORE: (No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Arthur Krause

(a) RESIDENCE NO. 537 N. Lakewood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie B. Krause

6 DATE OF BIRTH (month, day, and year) Feb 2, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62		20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 80

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Leibold Bros.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edward Krause

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Selma Hintz

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Annie B. Krause

(Address) 537 N. Lakewood Ave

15 Filed FEB 23 1930 C. HAWKINS JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930, to Feb. 22, 1930, that I last saw h~~im~~ alive on Feb 21, 1930, and that death occurred, on the date stated above, at 4:10 a. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

Mitral insufficiency

myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical findings

(Signed) L. C. Bobbitt, M. D.

Feb. 22, 1930 (Address) 447 N. Lakewood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 2/25/1930

ADDRESS

20 UNDERTAKER Wm Cook 1217 St Paul St

TION is very important. See instructions on back of

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54339

CERTIFICATE OF DEATH

88

E 54339

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 110 Scott St., 18-24 Ward)

2-FULL NAME Henry J. Kruse

(a) RESIDENCE NO. 110 Scott St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 12/2/1898

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	31	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bartlett-Hayward

9 BIRTHPLACE (city or town)
(State or country) Baltimore.

PARENTS

10 NAME OF FATHER Herman Kruse

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie Wahaus

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Herman Kruse
(Address) 110 Scott St

FEB 23 1930 HAMILTON JONES, M. D. Registrar

PAT Feb

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zuller, M. D.

2/23. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Feb 24 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 129

E 54340

1—PLACE OF DEATH

REGISTERED NO. 15-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3701 Garrison Blvd. (Street) WARD

2—FULL NAME Samuel Ridout

(a) RESIDENCE NO. 3701 Garrison Blvd. WARD Plainfield N.J.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if foreign birth 74 yrs. 4 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmina E Ridout

6 DATE OF BIRTH (month, day, and year) Oct 22/1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	74	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Evangelist

(b) General nature of industry, business, or establishment in which employed (or employer) Religious 618

(c) Name of employer Self.

9 BIRTHPLACE (city or town) Annapolis
(State or country) Maryland

PARENTS

10 NAME OF FATHER Saml Ridout

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Winchester

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country) Maryland

14 Informant Mr Sid Ridout (son)
(Address) Plainfield N.J.

15 Filed ..... 19 ..... Registrar

23 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 22, 1930

17

I HEREBY CERTIFY, That I attended deceased from Feby 21, 1930, to Feby 22, 1930, that I last saw h.. alive on Feby 22, 1930 and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arterio-sclerosis

(duration) Nil yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) — yrs. — mos. Nil ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Herbert F. Steelmane, M. D.

, 19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Plainfield N.J. DATE OF BURIAL Feb 24 1930

20 UNDERTAKER Edward Mowbray & Sons ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

Dr nw Carey 37 W Preston St

100-001 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54341

E 54341

CERTIFICATE OF DEATH

REGISTERED NO. 28-64

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4100 Ethland ave ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Willa Boyd

(a) RESIDENCE NO. 4100 Ethland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 DATE OF BIRTH (month, day, and year) Sept 6th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER John Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hinkmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marion Bowles

(Address) 4100 Ethland ave

15 Filed FEB 23 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 19, 1930 to Feby 21, 1930; that I last saw h[illegible] alive on Feby 21, 1930, and that death occurred, on the date stated above, at 3 40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry H McCarty, M. D.

2-22, 1930 (Address) 37 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 2/24/1930

20 UNDERTAKER H. S. Hayhurst

ADDRESS 1850 W Baltimore St

H. HAMPTON JONES, M. D.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54342

CERTIFICATE OF DEATH

151

E 54342

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1805 Poplar Grove St. Ward 15-60

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Ulensdorfer

(a) RESIDENCE NO. 1805 Poplar Grove St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy Wernsdafer

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1850

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	79	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Electric Railway

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant Mrs. Dorothy Wernsdafer (Address) 1805 Poplar Grove St.

15 Filed C. HARRISON JONES, M. D. By: Registrar

B 2 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 6th 1929 to Feb. 20th 1930

that I last saw h.. alive on Feb. 20th 1930

and that death occurred, on the date stated above, at 10. P. m.

The CAUSE OF DEATH* was as follows:

Senile Gangrene of right foot

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jones C. Dickson, M. D.

Feb. 22 1930 (Address) 3065 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — Date of Burial Feb. 24 1930

20 UNDERTAKER Margaret D. Flynn — ADDRESS 1402 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 54343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

126 E 54343

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 17 WARD)

2-FULL NAME Goldeth Armacost

(a) RESIDENCE NO. 645 Orpington Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced, husband of wife of William Armacost

6 DATE OF BIRTH (month, day, and year) Nov 14-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George W Belt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Goldeth Armacost (Address) 645 Orpington Road

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10 1930 to Feb. 22 1930, that I last saw her alive on Feb. 22 1930, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

(1) Osteomyelitis, left femur

(2) Acute Nephritis

(duration) (1) - - - - 4 mos (2) - - yrs - - mos - 3 ds.

CONTRIBUTORY (Secondary) (1) Peritonitis general, (2) fecal fistula, left (duration) (1) ? yrs. (2) ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 21, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Clinical

(Signed) Benjamin Klotz M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grace Cemetery Baltimore

DATE OF BURIAL 2-25 1930

UNDERTAKER Edw C Upton ADDRESS Hampstead Md

CAUSE OF DEATH MUST be stated plainly. See instructions on back of certificates.

FEB 23 1930

HAROLD F. JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 54344

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 S. East Ave. ST. 26-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME AMELIA R. SEMMERS

(a) RESIDENCE NO. 401 S. East Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Semmers

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John F. Oliver

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eady West

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant Mr. Wm. Semmers (Husband)
(Address) 401 S. East Ave.

15 (C. HAMPSON JONES, M. D.)
FEB 23 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1930, to Feb 22, 1930, that I last saw her alive on Feb 22, 1930 and that death occurred, on the date stated above, at 7.00 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Sutton, M. D.

2/27/1930 (Address) 315 S. Highland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Feb. 25 1930

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS Baltimore St & Broadway

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54345

CERTIFICATE OF DEATH.

74-001 E 54345

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4311 Liberty Heights Ave WARD) 28-64

2-FULL NAME Ella Gilpin Wilson

(a) RESIDENCE NO. 4311 Liberty Heights Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 29, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired odd

(b) General nature of industry, business or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua K Gilpin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah A Gilpin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Dr Barrett Wilson
(Address) Rockville Md

15 Filed 3 23 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1930, to Feb 23, 1930, that I last saw her alive on Feb 21, 1930, and that death occurred, on the date stated above, at 9 a.m. m.

The CAUSE OF DEATH* was as follows:

Brain abscess and Cerebral Hemorrhage

(duration) ..... yrs. about mos ..... ds.

CONTRIBUTORY (Secondary) Debility from broken hip

(duration) 2 yrs. 3 mos. 4 ds. about

Was disease contracted ... place of death? .....

Did operation precede death? No Date of .....

Was there an autopsy? No

What confirmed diagnosis? .....

(Signed) M. L. Ingram, M. D.

3/23 1930 (Address) 2439 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville Md. — DATE OF BURIAL 3/25, 1930

20 UNDERTAKER Warner C. Humphrey — ADDRESS Rockville

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2331 33 E. 54346 — CERTIFICATE OF DEATH — x 129 V P 54346

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Dameshorse

(a) RESIDENCE NO. Alexandria Va ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White (Single, Married, Widowed, Divorced, (write the word)) [redacted]

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [redacted]

6 DATE OF BIRTH (month, day, and year) [redacted]

7 AGE: Years 68 | Months | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: James Smoot

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Frances Fares

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 24 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 23/30

17 I HEREBY CERTIFY, That I attended deceased from January 17, 1930, to Feb 23, 1930, that I last saw her alive on February 23, 1930 and that death occurred, on the date stated above, at 3-15 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2.2.30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E H Campbell Jr, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alexander Va.

DATE OF BURIAL: 2-23 1930

20 UNDERTAKER: P C Hall

ADDRESS: 1000 Pacca St

Important: See instructions on reverse side.

Spec.—2-29-28—1. F. B. [illegible]

E 54347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54347

REGISTERED NO. 1-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 W. Mulberry ST. 17-2 (WARD)

2—FULL NAME Cora Montgomery

(a) RESIDENCE NO. 702 W. Mulberry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos. Montgomery Concluded.

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Clash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elmira Potts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elmira Clash
(Address) 707 W. Mulberry St

15 Filed ... 19 ... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21/30

17 I HEREBY CERTIFY, That I attended deceased from 2/18/30, to 2/21/30, that I last saw h[illegible] alive on 2/21/30, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Abt 2 (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Recurrent Bronchitis

Influenza Syphilis (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lowry, M. D.

2/21, 1930 Address 908 Shot St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2-24-1930
20 UNDERTAKER	ADDRESS
Jas. H. Skinner	1625 Druid St

Important: Use Permanent Ink

Spec.—12-9-25—A Co.—500 Bks.

54348

HEALTH DEPARTMENT—CITY OF BALTIMORE

VE 54348

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 816 Hanover St. 14-20 Ward)

2-FULL NAME Sandy B. Hoskins Hairston

(a) RESIDENCE NO. 816 Hanover St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Della Hairston

6 DATE OF BIRTH (month, day, and year): June 25 - 1880

7 AGE: 49 Years 7 Months 26 Days. IF LESS than 1 day ....hrs. or ....min.

50

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Lexington

(State or country): Va.

PARENTS

10 NAME OF FATHER: Patton Hairston

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Lexington Va.

12 MAIDEN NAME OF MOTHER: Patsy Hairston

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Lexington Va.

14 Informant: Mary E. Hairston

(Address): 243 E. Biddle St

Filed FEB 24 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 21, 1930 19

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 29 to Feb 21, 1930, that I last saw h[illegible] alive on Feb 21, 1930, and that death occurred, on the date stated above, at 5.50 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonic Carcinoma

4

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Colgan, M. D.

, 19 (Address) 1625 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. Date of Burial 2-24-30

20 UNDERTAKER: Jos. M. Skinner ADDRESS 1625 E. Madison St

very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54349 · HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 54349 +31 E 54349

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home + Infirmary WARD 6-9) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Mildred Einstein

(a) RESIDENCE NO. 10 Osborne ave. ST. Catonsville WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred X X 14 da. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 14-1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	16	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student H.S.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Jacob Einstein

11 BIRTHPLACE OF FATHER (city or town) Baltimore. (State or country) Md

12 MAIDEN NAME OF MOTHER Cassie Brooks Riley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore. (State or country) Md

14 Informant Mrs Ethel C. Einstein (Address) 10 Osborne Ave

15 Filed FEB 24 1930 19 H. M. JONES, M. Registrar

FEB 24 1930 C. HARRISON

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21-30

17 I HEREBY CERTIFY, That I attended deceased from 2-7-, 1930, to 2-21-, 1930 that I last saw he/she alive on 2-21-, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) 3 or 4 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 1 yr. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? — No

What test confirmed diagnosis? Smear from Spinal fluid

(Signed) Vernon H. Norwood M. D.

2/21. 1930 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Feb 24 1930

20 UNDERTAKER H. J. Tickner & Sons

ADDRESS Li La G

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54350

REGISTERED NO. 129 E 54350

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 S Gilmore ST. 19-28 WARD)

2-FULL NAME William H. Otterbein

(a) RESIDENCE NO. 440 S Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Otterbein

6 DATE OF BIRTH (month, day, and year) Feb 22, 1861

7 AGE	Years	Months	Days 24	If LESS than 1 day, hrs. or min.
	68	11	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Agnes Otterbein (Address) 440 S Gilmore St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/19/30, 1930, to 2/21/30, 19....., that I last saw h— alive on 2/19/30, 19....., and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Cl Diph Pneum

Cut Throat

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Culture

(Signed) Bernard J. Fury, M. D.

2/21/1930 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Feb 25 1930

20 UNDERTAKER Wm Cook — ADDRESS 1212 St Paul

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54351

E 54351 REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1604 E. Lanvale St., 8-17 Ward) 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Bourne

(a) RESIDENCE NO. 1604 E. Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11/1849

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	80	3	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England

PARENTS

10 NAME OF FATHER Samuel Bourne

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Mary Dykes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Elizabeth Caulk
(Address) 1004 E. Lanvale St.

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency-(Senile)
Accidently fell in home three weeks ago and fractured hip.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place af death?

Did an operation precede death? Cast by Dr. Kirby

Was there an autopay? no

What test confirmed diagnosis?

(Signed) J. K. Coulson M. D.

2/23/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, ar Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 2/24 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E. Pratt

OF DEATH in plain terms, so that it may be properly classified. Entire information important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

DS Potter

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54352

E 54352

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Townsend and or

City of BALTIMORE: (No. St. Josephs Hospital 13-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Schlesinger

(a) RESIDENCE NO. 744 W. North Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Frieda K Schlesinger

6 DATE OF BIRTH (month, day, and year) 5/19/1849

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	30	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town)

(State or country) Balto

PARENTS

10 NAME OF FATHER Geo. E. Schlesinger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Bach

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Geo. E. Schlesinger

(Address) 1723 E Lanvale St

15 Filed FEB 24 1930 H. [illegible] JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbolic Poisoning-Suicide

Acid

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.

(Coroner)

2/23/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mathews Cemetery — Date of Burial 2/25/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54353

CERTIFICATE OF DEATH.

E 54353

1.-PLACE OF DEATH BALTIMORE CITY HOSPITALS (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4-25 ST., WARD)

REGISTERED NO.

2.-FULL NAME Annie Burns or Irving

(a) RESIDENCE NO. 665 N. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 59 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Thos. Stackey ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Harvey ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed FEB 24 1930 H. [illegible] JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-23-30

17 I HEREBY CERTIFY, That I attended deceased from 12-13, 1928, to 2-23, 1930, that I last saw her alive on 2-23, 1930, and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 da.

CONTRIBUTORY (Secondary) Arteriosclerosis over 14

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas H. McLaw, M. D.

2-23, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cathedral

DATE OF BURIAL 2/25 1930

20 UNDERTAKER D. J. M. Cook

ADDRESS 1217 St. Paul St

TION is very important. See [illegible]

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54354

E 54354

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 N. Monroe St. St. 20-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Newton Frank Enos.

(a) RESIDENCE NO. 505 N. Monroe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie B. Enos.

6 DATE OF BIRTH (month, day, and year) April 17-1878.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Hiram Enos.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Boyer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Carrie B. Schwab. (Address) 505 N. Monroe St.

15 Filed FEB 24 1930 H. HARRISON JONES, M. D. Registrar

by [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/21 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 17th, 1930, to Feb 20, 1930, that I last saw h[illegible] alive on Feb 20, 1930, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) E. Kelly Hemmeter M. D.

2/22/30 (Address) 2007 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Feb. 24-1930.

20 UNDERTAKER Charles J. Schwab. — ADDRESS 505 N. Monroe St.

TION is very important. See instructions on

Spec.—8-16-29—L. F. S.—100 Bks.

232445 38 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54355 REGISTERED NO. E 54355

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-2 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Concetta Giaconucci

(a) RESIDENCE NO. 39 S East ave ST., WARD 9
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Domonick

6 DATE OF BIRTH (month, day, and year) Dec 9. 1891 unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Cosmo Parone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Laura Lalanne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 19 29, to Feb 22, 19 30 that I last saw h[illegible] alive on Feb. 22, 19 30. and that death occurred, on the date stated above, at 6 20 a. m.

The CAUSE OF DEATH* was as follows:

? syphilis of liver.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pernicious anemia.

(duration) ? 3 yrs. mos. da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Alexander Punton, M. D.

19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemtery.

DATE OF BURIAL Feb 25. 1930

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford av

Important: See instructions on back

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54356

CERTIFICATE OF DEATH

29 ✓ E 54356

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2159 Chelsea Terrace St. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George A. Immler

(a) RESIDENCE NO. 2159 Chelsea Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. — mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of— Caroline Immler

6 DATE OF BIRTH (month, day, and year) Feb 16 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Springfield (State or country) Ohio

PARENTS

10 NAME OF FATHER Geo Immler

11 BIRTHPLACE OF FATHER (city or town) Switzerland (State or country)

12 MAIDEN NAME OF MOTHER Elise Feth

13 BIRTHPLACE OF MOTHER (city or town) Switzerland (State or country)

14 Informant Mrs C. Immler (Address) 2159 Chelsea Terr

15 Filed FEB 24 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 22/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930, to February 22, 1930, that I last saw h... alive on February 21, 1930 and that death occurred, on the date stated above, at 5.45 A m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis 5 yrs
Arteriosclerosis 3 "

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Hy Prostatic Congestion

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary & Phenolsulphonaphthalein Test

(Signed) J. H. Delcarth, M. D.

Feb 23 1930 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	2/27/30
20 UNDERTAKER Geo Lemmon	ADDRESS W. Lexington St.

Spec.—8-16-29—L. F. S.—100 Bks.

233342 E 54357 — E 54357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 E 54357

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 27-47 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Murphy

(a) RESIDENCE NO. 4432 Linwood Av ST. Brenwood Av WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 - 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	1	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Bernard

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sadie Wainwright

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930, to Feb 22, 1930, that I last saw her alive on Feb 22, 1930 and that death occurred, on the date stated above, at 345 A m.

The CAUSE OF DEATH* was as follows:

Tbc meningitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4432 Brenwood Ave

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J W Bickford M. D.

2/22 1930 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Feb 25 1930

20 UNDERTAKER J Hemp Fields — ADDRESS 1200 N Lombard

Important: Do not write above this line.

FEB 24 1930 C. MAN... Johns H...

Spec.—8 16-29—L. F. S.—100 Bks.

E. 54358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 54358 REGISTERED NO. E 54358

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 722 N Luzerne Ave WARD 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Glenn Gill

(a) RESIDENCE NO. 722 N Luzerne ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie C Gill

6 DATE OF BIRTH (month, day, and year) Jan 18 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Harry Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary E Glenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Elsie C Gill

(Address) 722 N Luzerne Ave

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24/30

17 I HEREBY CERTIFY That I attended deceased from Jan 20, 1930, to Feb 21, 1930, that I last saw h live on 2/21/30, 19 and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Dilatation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

2/24/30 (Address) 800 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Natore of Injory, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 2/24/30

20 UNDERTAKER John Weirich

ADDRESS 2008 Aisquith

Imperfect: Illegible, Mutilated, Illegible

B24 1930

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54359

E 54359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 9-46 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Charles Coulter

(a) RESIDENCE NO. 1700 Carswell St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: --

6 DATE OF BIRTH (month, day, and year): March 28, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Coulter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Hay ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Records of Baltimore City Hospitals

15 Filed FEB 24 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-22-30

17 I HEREBY CERTIFY, That I attended deceased from 2-20-30, 19..., to 2-22-30, 19...,

that I last saw him alive on 2-22-30, 19...,

and that death occurred, on the date stated above, at 1:30 A.m.

The CAUSE OF DEATH* was as follows:

Rupture of Bladder (suspected)

over

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin W. McLean, M. D.

2-22 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: Feb 25 1930

20 UNDERTAKER: John Meenehan

ADDRESS 2008 Orleans

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54360

CERTIFICATE OF DEATH

101-006

E 54360

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2614 Jefferson ST., 7-10 WARD)

2—FULL NAME Hettie Dix

(a) RESIDENCE NO. 2614 Jefferson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Dix

6 DATE OF BIRTH (month, day, and year): 2/16/1869

7 AGE: Years 61 | Months — | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Geo Collier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Mannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Price Webster

(Address) 2614 Jefferson Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/22/1930

I HEREBY CERTIFY, That I attended deceased from Jan 3 1930 to Feb 22, 1930, that I last saw h[illegible] alive on Feb 22 1930 and that death occurred, on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Cancer of Pancreas

(duration) yrs. 1/2 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Thos Jenkins, M. D.

(Address) 2238 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wicomico Co Md

DATE OF BURIAL: 2/25/30

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 Orleans

Important. Do not write above this line.

FEB 24 1930 REGISTRAR'S DISTRICT NO.

Cor.—10-10-29—A Co.—100 Bks.

E 54361

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-004

E 54361

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) John Hopkins Hospital St., 12-50 Ward

2-FULL NAME Major Lyman Patterson

(a) RESIDENCE NO. 2905 N. Charles St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catheryne C. Patterson nee Capel

6 DATE OF BIRTH (month, day, and year) Aug 13/1898

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
✓	31	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Air Pilot
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Curtiss Co

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. J. B. Patterson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Illinois

12 MAIDEN NAME OF MOTHER Eleanor H. Lay

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14 Informant Col. Wm. Lay Patterson
(Address) War Dept. Washington, D.C.

Filed FEB 24 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22/30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull & other injuries-
Accidental crash from air of
aeroplane which he was testing.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Logan Field
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) J. S. H. Callen, M. D.
2/23/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington National Cem.

DATE OF BURIAL Feb 24/30

ADDRESS

20 UNDERTAKER Harry L. Witzke. 4101 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Entries must be made in all cases. All items are important. See instructions on back of certificate.

Spec.—2-28-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54362

CERTIFICATE OF DEATH

31 V

E 54362

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospitals 18 WARD)

2—FULL NAME Ida Venker

(a) RESIDENCE NO. 1004 S. Kenwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced (or) WIFE of John Venker

6 DATE OF BIRTH (month, day, and year) Aug. 31, 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63 64	5	20 21		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thos. Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Date received EB 24 1930 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1930 to Feb. 21, 1930 that I last saw h.er alive on Feb. 21, 1930 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. ½ mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas Ghrnaldy M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemtry

DATE OF BURIAL Feb. 25, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54363

E 54363

CERTIFICATE OF DEATH.

REGISTERED NO. 11-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 S. Clinton ST. 76-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Smith.

(a) RESIDENCE NO. 407 S. Clinton ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Smith

6 DATE OF BIRTH (month, day, and year) March 1st 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 1 051

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo. W. Jones

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Sarah A. Townsend

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Henry Smith (Husband) (Address) 407 S. Clinton St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to Feb 22, 1930, that I last saw her alive on Feb 21, 1930, and that death occurred, on the date stated above, at 6 45 a m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 14 da.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 9 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. Heckard M. D.

(Address) 320 N. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Feb 25 1930

20 UNDERTAKER Lilly & Sons — ADDRESS 403 N. Howard

E. HARRISON JONES, M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54364

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54364

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital

REGISTERED NO. 10-36

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Weinkam

(a) RESIDENCE NO. 6707 Holabird ST. 26 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 18th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John A. Weinkam

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Hammel

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant John A. Weinkam
(Address) 6707 Holabird ave.

15 Filed FEB 24 1930, 19 .... HAMP... JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 22nd 1930

17

I HEREBY CERTIFY, That I attended deceased from February 10th 1930 to February 22nd 1930, that I last saw h.. alive on February 22nd 1930 and that death occurred, on the date stated above, at 6 00 P. m.

The CAUSE OF DEATH* was as follows:

Goiter, summons of upper and lower lobes

(duration) ..... yrs. ..... mos. 5 da.

CONTRIBUTORY (Secondary) Otitis media

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Louis P. Gundry, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Feb. 26th 1930
20 UNDERTAKER Lilly & Zeiler Inc	ADDRESS 403 S. Wolfe St

Important. See instructions on the back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54365

E 54365

CERTIFICATE OF DEATH.

REGISTERED NO. 37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 S. Grundy ST., 26 WARD)

2-FULL NAME Pauline M. Fleming

(a) RESIDENCE NO. 632 S. Grundy ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1st 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Edwd. R. Fleming

11 BIRTHPLACE OF FATHER (city or town) Cambridge Md
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Tolliver

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Theresa T. Fleming (Mother)
(Address) 632 S. Grundy St

15 Filed FEB 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from January 10th, 1929, to Feb 21st, 1930, that I last saw h alive on Feb 21st, 1930, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Otitis Media (Hemorrhagic Septic)

(duration) 1 yrs. 1 mos da.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams, M. D.

Feb 24 1930 (Address) 2360 Eutaw place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL Feb. 25 1930

20 UNDERTAKER Lilly & Geiselhart

ADDRESS 1033 S. Wolfe St

HOW IS very important

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54366

CERTIFICATE OF DEATH

199 ✓

E 54366

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) University Hospital St., 18-26 (Ward)

2-FULL NAME Carrie Young

(a) RESIDENCE NO. 213 Cox Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Lottie Herbst

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Maggie Turner
(Address) 607 George St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis due to fractured Skull. Homicide.
Struck on head flat-iron

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 213 Cox alley

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Zellers M. D.

2/27. 1930. (Address) 2239 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	2/24 1930
20 UNDERTAKER Samuel F. Hendrix	ADDRESS 538 N Bdle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of the cause is important. See instructions on back of certificate.

C. H. JONES, M. D. Registrar

Mayne.

Spec.—1-30—M. & T.—250 Blks.

E 54367

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54367

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3405 E. Fayette ST. 16-29 WARD)

2-FULL NAME Anna Beigel

(a) RESIDENCE NO. 3405 E. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 44 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard Beigel

6 DATE OF BIRTH (month, day, and year) July 19-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	75	7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer) ooo
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant John G. Beigel
(Address) 3405 E. Fayette St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 '30

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1930, to Feb 23, 1930, that I last saw her alive on Feb 23/ 1930, and that death occurred, on the date stated above, at 2 45 a.m.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
(duration) ... yrs. ... mos. 1 ds.
CONTRIBUTORY (Secondary) Influenza
(duration) ... yrs. ... mos. 6 ds.

18 Where was disease contracted if not at place of death? Not known
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None
(Signed) Richard I Engleman M.D.
, 19 (Address) 1514 E Baltimore Balto

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL Feb 26 19 30

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager St

REGISTERED JONES, M. D. Registrar

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54368 × 101-001 E 54368

CERTIFICATE OF DEATH

REGISTERED NO. 425

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteer Jamaica Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E Young

(a) RESIDENCE NO. Glenartney. Colay, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~0~~ yrs. ~~0~~ mos. 4 ds. How long in U. S., if foreign birth 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Young.

6 DATE OF BIRTH (month, day, and year) Aug 11th 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	56.	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Sarah L. Young.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Sidnia Lovell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va.

14 Informant Mrs Esther Young.

(Address) Glenartney Colay Md.

15 Filed ..., 19 C. HAMPTON JONES, M. D. Registrar

FEB 24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 23rd 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1930, to Feb. 23, 1930, that I last saw him alive on Feb. 23, 1930, and that death occurred, on the date stated above, at 10:15 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) H. E. Larson, M. D.

2/23/1930 (Address) Halethorpe Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fair View E Bridgeville — DATE OF BURIAL 2/25th 1930

20 UNDERTAKER John Howard & Son. — ADDRESS Bridgeville Del

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks. See Other Side E-54369.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54369 E 54360

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens (Street) 25-77 (Ward) 86-00

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Janley

(a) RESIDENCE NO. St Mary's Ind School ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): ~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~

6 DATE OF BIRTH (month, day, and year) March 1- 1915

7 AGE: Years 15 Months 11 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School. pd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Janley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wm J. Janley Md

12 MAIDEN NAME OF MOTHER Julia Farrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Father) Wm Janley
(Address) 925 Hollins St

15 Filed ....., 19..... C. HAMPSON JONES, M. D. Registrar

B 2 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-23 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-23, 1930, to 2-23, 1930, that I last saw him alive on 2-23, 1930, and that death occurred, on the date stated above, at 3.55 p m.

The CAUSE OF DEATH* was as follows:

Otitis Media Complicated by Meningitis

(duration) ..... yrs. ..... mos. 2 wks. ..... da.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Exam of Spinal fluid

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mem Cathedral — DATE OF BURIAL: Feb 26 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 124 St Paul

Feb.24, 1930

Dr. C. Hampson Jones,

In complyance with your request I hereby certify that the death certificate of William E. Janley, age 14yrs, 11mo., 22 days who died at St. Agnes Hospital, on February 23rd, 1930 was mislaid or lost while in my office and we sent to the hospital today and received a duplicate of same, upon which you have issued a burial permit

Signed,
William Cook
William Cook

STATE OF MARYLAND
CITY OF BALTIMORE

Subscribed and sworn to before me this 24th day of February 1930

Ralph P. Dolby
Notory public.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54370

CERTIFICATE OF DEATH

E 54370

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1432 N. Eden St., 9-18 Ward)

2-FULL NAME Josephine Gontrum

(a) RESIDENCE NO. 1432 N Eden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William T. Gontrum

6 DATE OF BIRTH (month, day, and year) Oct 17/1847

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	82	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Albert Gontrum
(Address) 1432 N. Eden St

15 Filed FEB 24 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 20/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminatin Gas Asphixiation
Accidental-Probably tea kettle
boiled over on gas stove.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Culver, M. D.

2/23/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem.

DATE OF BURIAL 2/24/30

20 UNDERTAKER Holt & Turner

ADDRESS 1402 N Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 54371

E 54371

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1101 Mc Kean St.) 16-27 (Ward)

2-FULL NAME Julia A. Horning

(a) RESIDENCE NO. 1101 Mc Kean St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Edit statements on this certificate. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph A.

6 DATE OF BIRTH (month, day, and year) Jan 11 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	10	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John L. Garrison

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Miller.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant John L. Garrison
(Address) 1101 Mc Kean St.

15 Filed ..... 19.. Registrar

FEB 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ..... M. D.
(Address) ..... Coroner

Feb 24 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL Feb 25 1930

20 UNDERTAKER Josiah Syfer

ADDRESS 1604 N. Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 54372

CERTIFICATE OF DEATH

E 54372

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4920 Queensbury ST.) 27-5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Franklin Workman

(a) RESIDENCE NO. 4920 Queensbury Ave. Balto. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	14	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER [redacted] Workman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Rosenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant J. Lewis

(Address) 1439 E. Balto.

15 Filed 2-24-1930 C. HAMBLETON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930 to ....., 19..., that I last saw him alive on Feb. 23. 1930 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no Chemical exam.

What test confirmed diagnosis?

(Signed) ....., M. D.

, 19 (Address) G. W. Beckley 327 Belmont Ave

*State the Disease causing death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash. Road

DATE OF BURIAL 2-27-19 30

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54373

E 54373

CERTIFICATE OF DEATH

REGISTERED NO. 65001

1—PLACE OF DEATH Mercy Hosp.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4-25 ST. WARD)

2—FULL NAME James Kenny

(a) RESIDENCE NO. Greene (200 block) ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York

(State or country)

PARENTS

10 NAME OF FATHER Marks

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Carroll

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant

(Address) UNIV

15 Filed FEB 24 1930 19 Registrar

FEB 24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-20-1930

17 I HEREBY CERTIFY, That I attended deceased from 2-8-, 1930, to 2-20, 1930,

that I last saw him alive on 2-20, 1930

and that death occurred, on the date stated above, at 3 35 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Lymphoid Leukaemia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

2/20, 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ERSITY OF MARYLAND.

DATE OF BURIAL FEB 24 1930 19

20 UNDERTAKER Commissioner Health

ADDRESS

Important: See instruction on back

Morgue

Spec.—1-12-23—M&T—500 Bks.

E 54374 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54374

CERTIFICATE OF DEATH.

162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 E. Lexington ST. 5-8 WARD)

2-FULL NAME Christopher Mitchell

(a) RESIDENCE NO. 1209 E. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-20-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work col

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Christopher Mitchell

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Hazel Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Hazel Smith

(Address) 1209 E Lexington St

15 Filed FEB 24 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1930, to Feb 21, 1930, that I last saw him alive on Feb 21, 1930, and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Hebelcompte, M. D.

, 19 (Address) 1163 N. Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL FEB 24 1930 19

20 UNDERTAKER [illegible]

ADDRESS

Per. Wm. E. WOODALL

TION is very important See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54375

CERTIFICATE OF DEATH

100-001

E 54375

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 911 W. Lexington St. 16-7 (Ward)

2-FULL NAME Harold Bull

(a) RESIDENCE NO. 911 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov 3 - 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Harold Bull

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S.C.

12 MAIDEN NAME OF MOTHER Lola Goodson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S.C.

14 Informant Harold Bull
(Address) 911 W Lexington St

15 Filed 19 Registrar

FEB 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb. 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

2/24 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Mt Auburn Cemetery

DATE OF BURIAL Feb 24 30

20 UNDERTAKER
Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54376

90 E 54376

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 613 S. Dirham St. (Ward) 2-4

2-FULL NAME John Zubrowske

(a) RESIDENCE NO. 613 S Dirham St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? 40 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leokadia Zubrowski,

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	64	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer,
(b) General nature of industry, business, or establishment in which employed (or employer) 0 40
(c) Name of employer

9 BIRTHPLACE (city or town) Gosdowa,
(State or country) Poland,

PARENTS

10 NAME OF FATHER Albert Zubrowski,

11 BIRTHPLACE OF FATHER (city or town) Gosdowa,
(State or country) Poland,

12 MAIDEN NAME OF MOTHER Agatha Chieciok,

13 BIRTHPLACE OF MOTHER (city or town) Gosdowa,
(State or country) Poland,

14 Informant Mrs. Leokadia Zubrowski, Wife,
(Address) 613 S. Dirham St.

15 Filed FEB 24 1930. 16 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. — mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) G. B. Ladas M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem.

DATE OF BURIAL Feb 25 1930

20 UNDERTAKER M. F. Sadowske.

ADDRESS 2215 Pulham Ave.

OF DEATH in plain terms, so that it may be properly classified. EARLY STATEMENT OF OCCUPATION important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E. 54377

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 54377

CERTIFICATE OF DEATH

E 54377

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840 Wilhelm ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Schanfelter

(a) RESIDENCE NO. 1840 Wilhelm ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Schanfelter

6 DATE OF BIRTH (month, day, and year) Jan 20" 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Miss Hess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Theile

(Address) 1840 Wilhelm Street

15 Filed 2-4 1930 R. [illegible] C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February, 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 14 1930 to Feb 22 1930, that I last saw h[illegible] alive on Feb 22 1930, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) 8 hrs.

CONTRIBUTORY (secondary) Myocarditis, Chronic

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

2/24 1930 (Address) 1729 West Lombard Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Feb. 25" 1930
20 UNDERTAKER Joseph B Cook	ADDRESS 1008 W. Balt

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 ✓

E 54378

CERTIFICATE OF DEATH

E 54378

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST., 10-14 WARD)

2—FULL NAME Agnes Weaver

(a) RESIDENCE NO. Preston + Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt Md.
(State or country) " "

PARENTS

10 NAME OF FATHER " "

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston + Valley Sts

15 FILED FEB 24 1930 C. HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 23, 1930, that I last saw h... alive on Feb 22, 1930, and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular

Pneumonia (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY
(Secondary) (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W Remsburg, M. D.

2/24/30 (Address) 1216 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Feb 24 1930

20 UNDERTAKER Rita Wiedefeld 914 Greenmount Ave — ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54379 X 90 E 54379

CERTIFICATE OF DEATH

REGISTERED NO. 424

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. Md. General Hospt ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A. Gray

(a) RESIDENCE NO. Trappe Rd. & North Point Road WARD Balto Co Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elsa G. Gray.

6 DATE OF BIRTH (month, day, and year) 12/29/1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment In which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Md.

PARENTS
10 NAME OF FATHER James T. Gray
11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Md.
12 MAIDEN NAME OF MOTHER Mary B. Parke
13 BIRTHPLACE OF MOTHER (city or town) Balto Co.
(State or country) Md.

14 Informant Hospital Records
(Address)

15 Filed 3 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23/30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 8, 1930, to Feb. 23, 1930, that I last saw h. alive on Feb. 23, 1930, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular cardiac disease (General) (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Sub-acute bacterial Endocarditis (duration) 9½ mos. da.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) [illegible]
(Address) [illegible]

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cem DATE OF BURIAL Feb 26 1930

20 UNDERTAKER Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette

Important. See instructions on back of this sheet.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54380 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54380

CERTIFICATE OF DEATH X 47

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 4-7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Gilmore

(a) RESIDENCE NO. Baldwinsville N.Y. ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 16 days How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baldwinsville N.Y.

PARENTS

10 NAME OF FATHER Arthur ?

11 BIRTHPLACE OF FATHER (~~city or town~~) N.Y. (State or country)

12 MAIDEN NAME OF MOTHER Galvin ?

13 BIRTHPLACE OF MOTHER (~~city or town~~) N.Y. (State or country)

14 Informant Husband (Address)

15 Filed 2 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23/30

17 I HEREBY CERTIFY, That I attended deceased from 2-7, 1930, to 2-23, 1930, that I last saw her alive on 2-23, 1930 and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Sarcoma Breast

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) J Geyko, M. D.

2/24, 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Syracuse N Y	2/24/30
20 UNDERTAKER	ADDRESS
Geo A Darby Sons	Baldwinsville

Important. See instructions on back of Certificate

Spec.—1-30—M. & T.—250 Blks.

E 54381 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54381

31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 16-23 WARD

2-FULL NAME Clara Morris

(a) RESIDENCE NO. 1003 Woodyear St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer

6 DATE OF BIRTH (month, day, and year) March 20, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West Moreland

(State or country) Va.

PARENTS

10 NAME OF FATHER Robert Gillis

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Susan Braxton

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 2 4 1930, 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-23-30

17 I HEREBY CERTIFY, That I attended deceased from 2-18-30, 19..., to 2-23-30, 19...,

that I last saw her alive on 2-23-30, 19...,

and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

~~Chronic~~ Tuberculosis of Lungs

(duration) yrs. 4? mos ..... ds.

CONTRIBUTORY (Secondary) Vincents Angina & Mouth

Intestines (duration) over yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical: Autopsy

(Signed) Warren W. McLane, M. D.

2-24, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Feb 26 1930

20 UNDERTAKER Jas. W. Chase & Son

ADDRESS 1400 W. Baltimore

THIS IS VERY IMPORTANT. See instructions on reverse side.

Spec.—1-30—M. & T.—250 Bks.

E 54382 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54382

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 19-27 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Johnson

(a) RESIDENCE NO. 519 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Bill Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 2 4 1930 Agent C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-18-30

17 I HEREBY CERTIFY, That I attended deceased from 5-9-29, 19..., to 2-18-30, 19...,

that I last saw her alive on 2-18-30, 19...,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic

(duration) ... yrs. 8 mos ... ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) ... yrs. 8 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren McLean, M. D.

2-19, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL 2/25 1930

20 UNDERTAKER Edward Eaton ADDRESS FEB 24 1930

Form B. W. & S. Co. 1-30

Spec.—1-30—M. & T.—250 Blks.

E 54383 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54383

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 4-76 ST.) WARD

2-FULL NAME Charles Johnson

(a) RESIDENCE NO. 708 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Bash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hospitals UNIV

15 Filed 2 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-19-30

17 I HEREBY CERTIFY, That I attended deceased from 2-14-30, 19..., to 2-19-30, 19...

that I last saw h... alive on 2-19-30, 19...,

and that death occurred, on the date stated above, at 1:10A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, (duration) ... yrs. ... mos. 7? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin McCrea, M. D.

2-19, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS FEB 24 1930

PRINTING OFFICE

Spec.—8-16-29—L. F. S.—100 Blks.

2334 E 54384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 54384

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph George

(a) RESIDENCE NO. 421 No. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Haiti

PARENTS

10 NAME OF FATHER Joseph George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Haiti

12 MAIDEN NAME OF MOTHER Sadie Speak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Haiti

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL JOH

15 Filed FEB 24 1930, 19 C. HAMPSON JONES, M. D. Registrar

2 4 1930 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-18-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1930, to Feb 18, 1930, that I last saw h. alive on Jan 18, 1930 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Disease of long standing - enlarged liver - gradual but increasing ascites, epistaxis. Jaundice; arteriosclerosis, myocarditis, cirrhosis liver (Laennec) ascites. tuberculosis. (duration) 20 yrs. mos. ds.

CONTRIBUTORY 7
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Post mortem

(Signed) [illegible] M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL NS HOPKINS HOSPITAL

DATE OF BURIAL

FEB 24 1930

20 UNDERTAKER Commissioner Health

PRESS

Pat. Wm. E. Woodall

Important. See instructions on back of certificate

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54385

CERTIFICATE OF DEATH

E 54385

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3-4 WARD)

REGISTERED NO. 56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Williams

(a) RESIDENCE NO. 512-S. Carolina ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 1 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md—

PARENTS

10 NAME OF FATHER William Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Julia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 Registrar

Md 4381

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1930, to Feb 21, 1930, that I last saw him alive on Feb. 21, 1930 and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Undetermined

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. O. G. Warn, M. D.

2/23 1930 (Address) Johns Hopkin Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

FEB 24 1930

Important. See instructions on back of Certificate

Spec.—8-16-29—L. F. S.—100 Bks.

E 54386

E 354386 597

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Jones

(a) RESIDENCE NO. 1368 Fremont ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-12-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hawkins

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL JOHNS

15 FILED FEB 24 1930 C. HAMPSON JONES, M. D. Registrar

B 24 1930 4382

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-17-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1930, to Feb 17, 1930, that I last saw him alive on Feb 17, 1930 and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia - (primary)
Otitis media -

4 weeks. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Corneal ulcerus.

4 weeks. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Benjamin E. Hodge, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

20 UNDERTAKER Commissioner Health.

ADDRESS

DATE OF BURIAL 19

FEB 24 1930

Per. Wm. E. Woolsey

Important. See instructions on back of Certificate

Spec.—1-30—M. & T.—250 Blks.

Dr. S. Whitmore 1810 Eutaw Place
Lot 1129

E 54387 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54387

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2201 Callow Ave St.) 13-59 (WARD)

2-FULL NAME Emily Mc Gilloway

(a) RESIDENCE NO. 2201 Callow Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Daniel J.

6 DATE OF BIRTH (month, day, and year) 3/25/1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	10	27 17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Kavanaugh
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Katherine Doyle
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Margaret Cochran
(Address) 2201 Callow Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22nd 1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1921, to Feb 22, 1930.
that I last saw h.. alive on Feb 22, 1930;
and that death occurred, on the date stated above, at 2.30 P. m.
The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) arterio-sclerosis

(duration) 15 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis?
(Signed) Samuel Whitmore M. D.
, 19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL 2/25/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

FEB 24 1930

Spec.—1-30—M. & T.—250 Blks.

Dr. Susie 4509 Liberty Hgts Ave Lib 6285

E 54388 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54388

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3206 Brightwood Ave (Ward) 28-6

2-FULL NAME Oliver Jarvis Shakespeare

(a) RESIDENCE NO. 3206 Brightwood Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Susie Shakespeare

6 DATE OF BIRTH (month, day, and year) 12/11/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER Oliver Shakespeare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF ~~Mother~~ Elizabeth Jane Freebungers

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Harry C. Shakespeare

(Address) 3206 Brightwood Ave

15 Filed 2-24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Feb 22, 1930, that I last saw him alive on Feb 22, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Hypostatic congestion Lungs

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ~~No~~ Date of .....

Was there an autopsy? —

What test confirmed diagnosis? Physical findings

(Signed) A. C. Emmell, M. D.

19 30 (Address) 4509 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 2/25/1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

FRONT VERY important

8-16-29—L. F. S.—100 Bks.

E 54389

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54389

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 N. Madiera St. ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Base

(a) RESIDENCE NO. 825 N. Madiera St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Base

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Pisek

(State or country) Czecho-Slovakia

PARENTS

10 NAME OF FATHER John Pisinger

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Czecho-Slovakia

12 MAIDEN NAME OF MOTHER Anna Carka

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Czecho-Slovakia

14 Informant: Frank Base

(Address) 217 N Madiera St

15 Filed: 2 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22/30

17 I HEREBY CERTIFY, That I attended deceased from [illegible] 20 1930 to Feb 20 1930

that I last saw h[illegible] alive on Feb 20 1930

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) yrs. 6 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H Bauer M. D.

Feb 24 1930 (Address) 804 S 16th Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: Feb. 25 1930

20 UNDERTAKER: Frank Cvach & Son

ADDRESS: 1906 Ashland

Important. See instruction on the back of this certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54390

REGISTERED NO. **E 54390**

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 209 N Arlington St., (Ward) 17th

2-FULL NAME Wm. T. Graham

(a) RESIDENCE NO. 209 N. Arlington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 9 1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	3	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John Graham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Liza Coats

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary A Parker
(Address) 209 N Arlington

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

B 2-4 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke, M. D.

Feb 22, 1930 (Address) 3601 Fait Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkis Church Calvert Co Md

DATE OF BURIAL 2/25 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1390 W Lombard St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54391

CERTIFICATE OF DEATH

100-001

E 54391

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1743 E Pratt St. 2-4 WARD)

2—FULL NAME Anna [redacted] Wiszniewska

(a) RESIDENCE NO. 1743 E Pratt St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
61	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Ida Kulwicka
(Address) 129 N. Lakewood Ave

15 Filed ..., 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Febr 15, 1930, to Febr 22, 1930
that I last saw h alive on Febr 21, 19
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Nathan Nelson M. D.

, 19 (Address) 117 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Feb 25 19 30

20 UNDERTAKER	ADDRESS
John M Weber	401 S Chester

Important. See instructions on back of this page.

3 24 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54392 001 ✓ E 54392

CERTIFICATE OF DEATH

E 54392

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1733 Guilford Ave. 17-19 Ward)

2-FULL NAME David S. Connelly

(a) RESIDENCE NO. 1733 Guilford Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie L. Connelly

6 DATE OF BIRTH (month, day, and year) June 16 1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
64	63	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Telegraph Operator
(b) General nature of industry, business, or establishment in which employed (or employer) R.R.
(c) Name of employer Rennsylvania R. R.

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER David Connelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Jennie -----

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Annie L. Connelly
(Address) 1733 Guilford Ave.

Filed 19 C. Hampton Jones, M. D. Registrar

2 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Talbot, M. D.

Feb 25, 1930 (Address) 1733 Guilford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Feb. 25, 1930
20 UNDERTAKER E. Leroy Stiffler, Inc.	ADDRESS 125 E. North Ave.

E. Leroy Stiffler, Inc.

OF DEATH in plain terms, so that it may be properly classified. EXACT statement of occupation is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

CERTIFICATE CORRECTED 4-23-31 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54393

100-9

E 54393

CERTIFICATE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 18-No Ward)

2-FULL NAME Bessie Bee Jones

(a) RESIDENCE NO. 1007 N Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, ~~Married~~, ~~Widowed~~ or ~~Divorced~~, (write the word)
F	C	Single Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 4 1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
27	23	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Christopher Columbus Robinson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Vickson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Ernie Robinson
(Address) 1001 N. Carey St

15 Filed 2 4 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 1 yrs. mos. (4) da.

CONTRIBUTORY (Secondary) Cy Carcinoma

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) G. C. Hampson Jones, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Mt Carmel Cemetery	Feb 25 1930
20 UNDERTAKER	ADDRESS
Eugene Waters	1433 Edmondson Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54394

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54394

CERTIFICATE OF DEATH

REGISTERED NO. 24-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 341 Dolphin St. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy Wells

(a) RESIDENCE NO. 341 Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic - Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant A. Gee

(Address) 341 Dolphin St

15 C. HAMPSON JONES, M. D.

2 4 1930 By ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/22/30

17 I HEREBY CERTIFY, That I attended deceased from 2/17, 1930, to 2/22, 1930

that I last saw her alive on 2/22, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Hamilton, M. D.

2/24/1930 (Address) 912 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 2/25/1930

20 UNDERTAKER Geo. H. Holland — ADDRESS 31 Druid Hill

IMPORTANT: See instructions on the back of this certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Worthmann ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54395

CERTIFICATE OF DEATH

129 E 54395

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 E Lafayette Ave ST. 8-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A Worthmann

(a) RESIDENCE NO. 2001 E Lafayette Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Worthmann

6 DATE OF BIRTH (month, day, and year) 3/19/875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	54	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer Oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Adolph Worthmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Stalang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Amelia Worthman

(Address) 2001 E Lafayette Ave

15 Filed FEB 25 1930, HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from December 27, 1929, to February 24, 1930

that I last saw h living alive on February 6, 1930

and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterial Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross & Microscopic Autopsy

(Signed) Clement A Cicciarelli M. D.

2/27 1930 (Address) 2025 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 2/27 1930

20 UNDERTAKER Albert L Stitz Jr

ADDRESS 1606 N Chester St

Important: Be sure to answer all questions.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 54396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 54396

REGISTERED NO. 76-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Charlotte Ave ST. WARD)

2-FULL NAME John H. Keller

(a) RESIDENCE. NO. 1605 Charlotte Ave. ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa C Keller

6 DATE OF BIRTH (month, day, and year) 9/1/1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	90	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wrightsville Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Mrs Louisa C Keller
(Address) 1605 Charlotte Avenue

15 Filed FEB 25 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1927, to Feb 23, 1930 that I last saw him alive on Feb 23, 1930 and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. W. Keller, M. D.

Feb 24, 1930 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	2/26 1930

20 UNDERTAKER Albert L Hilt ADDRESS 1606 N Chester St

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

137

E 54397

E 54397

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 672 W Franklin St. 1725 Ward)

2-FULL NAME Amelia Robinson

(a) RESIDENCE NO. 672 W Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theo. Robinson

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	36	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Co Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Theo. Robinson
(Address) 672 W Franklin St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ... death on the day stated above.
(autopsy or inquiry)

The CAUSE OF DEATH* was as follows:

Fibroid Tumor

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Feb 24 30 Eleanor Brown, M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 2-25 1930

20 UNDERTAKER David Corbin

ADDRESS 916 Pa ave

FILL OUT CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54398

CERTIFICATE OF DEATH.

129 ✓ **E 54398**

REGISTERED NO. 6264

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 611 N. Paca St. 17-25 Ward)

2-FULL NAME Robert Ely Lyner

(a) RESIDENCE NO. 611 N. Paca St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Negro	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Lyner

6 DATE OF BIRTH (month, day, and year) Jan. 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
✓	26	one		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: meter of

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Baltimore Gas. Foundry Co

9 BIRTHPLACE (city or town) Hampstead

(State or country) N. C.

PARENTS

10 NAME OF FATHER Roland Lyner

11 BIRTHPLACE OF FATHER (city or town) Hampstead

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Rosa Johnson

13 BIRTHPLACE OF MOTHER (city or town) Hampstead

(State or country) N. C.

14 Informant Roland Lyner

(Address) 611 N. Paca St

15 Filed ....., 19 ..... Registrar

FEB 25 1930 U. H. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Feb 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1930 to Feb 22, 1930, that I last saw him alive on Feb. 20, 1930, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ....yrs. one mos. ....da.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical Examination

(Signed) Wm H. Watts, M. D.

Feb 24, 1930 (Address) 928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Garfield N.C. Date of Burial 2-25 1930

20 UNDERTAKER Leon Carter & Co ADDRESS 916 Pa ave

OF DEATH in plain terms, so that it may be properly classified. For Statistical Use Only
very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54399

CERTIFICATE OF DEATH 177

E 54399

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp St. 11-24 Ward)

2-FULL NAME Helen Berins

(a) RESIDENCE NO. 923 Madison Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Fmale	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day and year) 1926 - Nov 25th 26

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Berins

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Helen Lamb

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Wm Berins
(Address) 923 Madison Ave

15 Filed FEB 25 1930 HARRY JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.
The CAUSE OF DEATH* was as follows:

Accident
Scalding Fluid
Drank Lead Fr. Spring
(duration) fell over

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Negative
(Signed) H. Smith M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	2-25 1930
20 UNDERTAKER David Eaton	ADDRESS 816 Pc ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54400

E 54400
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. 1920 E. Pratt street St., 2-4 Ward)

2-FULL NAME Clarael Greenberg

(a) RESIDENCE NO. 1920 E. Pratt St St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Gertie Greenberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Greenberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Shano —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Gertie Greenberg
(Address) 1920 E. East St

Filed FEB 25 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. — da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. — da.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? Phy. Exam.
(Signed) [illegible] M. D.
. 19 (Address) 1920 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. — DATE OF BURIAL 2/25 1930

20 UNDERTAKER Jack Lewis 439 E. Balto St — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54401

CERTIFICATE OF DEATH.

E 54401

1-PLACE OF DEATH

City of BALTIMORE: (No. 606-5-Eaton St., 26th Ward)

Registered No. 167-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma May France

(a) Residence No. 606-5-Eaton St., 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 2/22/30

7-AGE. ✓ yrs. mos. 2 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto md

PARENTS

10-NAME OF FATHER. Alfred H. France

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto md

12-MAIDEN NAME OF MOTHER. Edith M Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto md

14- (Informant) Alfred H. France

(Address)

15- C. HAMPSON JONES, M. D. Registrar.

FEB 25 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 24, 1930

17- I HEREBY CERTIFY, That I attended deceased from 2/22, 1930 to 2/24, 1930

that I last saw her alive on 2/24/30, 1930

and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(about 7 months)

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/24, 1930 (Address) 633-5-Conkling

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary

DATE OF BURIAL. 2/25, 1930

20-UNDERTAKER. J. J. Moran

ADDRESS 3900 E Balto

Fill in all blanks. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54402 — 129 — E 54402

REGISTERED NO. 610

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2320 E Fairmount Ave. WARD)

2—FULL NAME Mary E. Friedel

(a) RESIDENCE NO. 2320 E Fairmount Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Aloysius Friedel

6 DATE OF BIRTH (month, day, and year): Mar 29-1877

7 AGE: Years 52 | Months 10 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Mudd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret McNally

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mary Coulbourn (Address) 2326 E. Fairmount Ave

15 FEB 25 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930, to Feb 23, 1930, that I last saw her alive on Feb 23, 1930, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Contra

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam (Physical)

(Signed) B O Kelly, M. D.

Feb 24 1930 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemet. DATE OF BURIAL: Feb 26 1930

20 UNDERTAKER: J. A. Tasker ADDRESS: 1013 N Fulton Ave

Important. See instructions on back

Spec.—2-29-28—L. F. S.—500 Bks.

E 54403

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54403

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. Hooper

(a) RESIDENCE NO. 404 Cedar Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. Isennock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Deane (Sister)

(Address) 5106 Bryan Park Ave

15 Filed Feb 25 1930, 19 H. [illegible] Jones M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930, to Feb. 24, 1930 that I last saw h.m alive on Feb. 24, 1930 and that death occurred, on the date stated above, at 10:47 p m.

The CAUSE OF DEATH* was as follows:

Scarlet- Fever

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Parkinsons Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron B. Tull, M. D.

2/25, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestnut Grove-Bolton Ld	Feb 25 1930
20 UNDERTAKER	ADDRESS
Wm J Tucker & Sons	Balto Md

Important. See instructions on back of Certificate.

FEB 25 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54404

CERTIFICATE OF DEATH

129 ✓ E 54404

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 N. Bradford ST., 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Schneider

(a) RESIDENCE NO. 904 N Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 11 mos. ds. How long in U. S., if foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	75	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) 00

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Adam Schneider

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margaret Kert

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mr. Joseph W. Schneider (Address) 904 N. Bradford St

15 Filed FEB 25 1930 WILLIAM F. JONES, M. D. Registrar by [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 25 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1928, to Feb 25, 1930 that I last saw her alive on Feb. 24, 1930 and that death occurred, on the date stated above, at 1.35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Vincent P. Cooke, M. D.

2/25, 1930 (Address) 845 N. Eutaw St. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL Feb. 28 1930

20 UNDERTAKER Henry Heck & Sons Inc. ADDRESS 1801 E Eager St

Important. See instructions on back of certificate

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54405

CERTIFICATE OF DEATH

31 ✓

E 54405

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 N. Washington ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Campbell

(a) RESIDENCE NO. 539 N Washington ST. " WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 2 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 20 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	20	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas J. Campbell

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Eleanor L. Evans

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Mr. Thomas J. Campbell

(Address) 539 N Washington Ave

15 Filed FEB 25 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) FEB 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930, to Feb 27, 1930, that I last saw h[illegible] alive on Feb 24, 1930 and that death occurred, on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) J. Edw. Talbot, M. D.

2/25, 1930 (Address) 1355 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Feb. 28 1930

20 UNDERTAKER Kenney Hoen & Sons, Inc.

ADDRESS 501 E Eager St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54406

CERTIFICATE OF DEATH

+ 172 ✓

E 54406

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1nd Ave/ St. 11-24 Ward)

2-FULL NAME Wm A. Jackson.

(a) RESIDENCE NO. Oxford Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 3-1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62	10	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Saml L. Jackson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Langfield

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Wm A Jackson
(Address) Oxford Md

15 Filed FEB 25 1930 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Fractured Skull
(duration) Sudden

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Oxford Md
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) H. Hartman, M. D.
Feb 27th (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oxford Md

DATE OF BURIAL 2/25 1930

20 UNDERTAKER Talbot Cook

ADDRESS 127 N Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 25 1930 HAMPSON JOHNS M. D.

Spec.—1-30—M. & T.—250 Bks.

E 54407

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54407

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1515 N. Bond ST. (WARD) 8-17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. J. Prell

(a) RESIDENCE NO. 1515 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Prell

6 DATE OF BIRTH (month, day, and year) Oct 29/1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Leather 045

(b) General nature of industry, business, or establishment in which employed (or employer) Bus

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Andrew Prell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Louisa Prell

(Address) 1515 N. Bond St

15 Filed FEB 25 1930 HARWOOD JONES, M. D. Registrar

By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930 to Feb 23 1930

that I last saw h.. alive on Feb 23, 1930,

and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W. H. Thomas, M. D.

Feb 23 30 (Address) 1228 Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Feb 26 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Eutaw St

TION is very important See instructions on back of certificate

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54408

E 54408

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1136 Cleveland St St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis E. Flock.

(a) Residence No. 1136 Cleveland St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white.

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Flock.

6-DATE OF BIRTH (month, day and year) Feb 4, 1874

7-AGE. 56 yrs. 0 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... printer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 063

(c) Name of employer..... not employed

9-BIRTHPLACE (city or town)..Fort Meyer, Va (State or Country),

PARENTS.

10-NAME OF FATHER, John George Flock

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Theresa Steible

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Charles H. Flock

(Address) 1136 Cleveland St.

15- 19..... C. HAMILTON JONES, M. D. Registrar.

FEB 25 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Feb. 24, 1930.

17- I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1929 to Feb 24, 1930

that I last saw h.. alive on Feb 24, 1930

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

absent

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) cardiac insufficiency

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? sputum tests

(Signed) Edgar A. Kemp M. D.

, 19 (Address) 3030 Edmondson Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL, 2/26/30, 19....

20-UNDERTAKER Geo. Lenibach

ADDRESS 520 N. Lyndhurst

Fill in all blanks. Follow instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54409

REGISTERED NO. E 54409

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 26-37 Ward)

2-FULL NAME Thomas Cerny

(a) RESIDENCE NO. 5115 O. Donell St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Julia Cerny

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ferness Hand
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Copper Workes

9 BIRTHPLACE (city or town)
(State or country) Checho Slovakia

PARENTS

10 NAME OF FATHER Thomas Cerny

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Checho Slovakia

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Checho Slovakia

14 Informant Julia Cerny Wife
(Address) 5115 ODonell St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

St Lar Acd
Traumatic Amputation
of Legs (duration) yrs. mos. ds.
Shock
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — —
Did an operation precede death? Yes Date of Dec 23
Was there an autopsy? No
What test confirmed diagnosis? Phys Exp
(Signed) C. C. Staley, M. D.
, 19 (Address) 1430 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	Feb 27 30
20 UNDERTAKER J. W. Bozewski, 1930	ADDRESS Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B 25 1930 PUC

Spec.—8-16-29—L. F. S.—100 Blks.

E 54410 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54410

CERTIFICATE OF DEATH

37-001

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 4-25 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Roberts

(a) RESIDENCE NO. 668 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16 1913

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
16	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Benj. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Corey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Benj Roberts (Address) 668 Vine St

15 Filed FEB 25 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 30, to Feb 21, 1930, that I last saw her alive on Feb 21, 1930 and that death occurred, on the date stated above, at 10 40 m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis ?

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis ?

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J Leyko, M. D.

2/21, 1930 (Address) J. Leyko

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery

DATE OF BURIAL Feb 25 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1363 Eastern Av

Important. See instructions on back of certificate.

Cor.—12-8-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54411

E 54411

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (a) Hurley Memorial Hospital 2557 Ward

2-FULL NAME Henry W. Tracy

(b) RESIDENCE NO. 1306 Weldon Circle St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of: Grace Tracy

6 DATE OF BIRTH (month, day and year): Sept. 23, 1885

7 AGE: Years 44 Months 4 Days 29. IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Maryland

(State or country)

10 NAME OF FATHER: Edward Tracy

11 BIRTHPLACE OF FATHER (city or town): Maryland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary L. Easton

13 BIRTHPLACE OF MOTHER (city or town): Maryland

(State or country)

PARENTS

14 Informant: Mrs. Irene Tracy

(Address) 1305 Weldon Circle

15 Filed: 3 25 1930 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The cause of death was as follows:

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....mos. .....ds.

(Signed) J. Lee Thornton M. D.

(Coroner)

2/24, 1930 (Address) 232 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: Feb. 25 1930

20 UNDERTAKER: Easton Sons ADDRESS: Ellicott City

very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54412

REGISTERED NO. 129 E 54412

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2937 Erdman Ave St., 8-43 (Ward)

2-FULL NAME William F. Funk

(a) RESIDENCE NO. 2937 Erdman Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residenre in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E. Funk

6 DATE OF BIRTH (month, day, and year) Nov 26/1871

7 AGE	Years	Months	Days 28	IF LESS than 1 day hrs. or min.
✓	58	2	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Collector 07
(b) General nature of industry, business, or establishment in which employed (or employrr) Hecht & Co
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Carroll G. Bayne (daught
(Address) 2937 Erdman Ave

FEB 25 1930

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24/30

17 I HEREBY CERTIFY, That I took charge of the remains deserибed above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History Relatives

(Signed) [illegible], M. D.

2/25/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 2-27-30

20 UNDERTAKER Margaret L Flynn — ADDRESS 1417 Eutaw St

Filed [illegible] 19

Registrar

Exact statement of OCCUPATION is very important. See instructions on back of certificate. Use words of ordinary use, so that it may be properly classified.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54413

100-001

E 54413

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 132 So. London Ave St. W 71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ethel Lee Luckett

(a) RESIDENCE NO. 132 So London Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 about yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ WIFE of George S. Luckett

6 DATE OF BIRTH (month, day, and year) April 6 - 1888

7 AGE: Years 41 Months 10 Days 17 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll County Md.

(State or country)

PARENTS

10 NAME OF FATHER Benjamin R. Jeffery.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Carroll Co. Md

12 MAIDEN NAME OF MOTHER Rosa Lee Warfield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carroll County Md

14 Informant George C. Shannon

(Address) 1700 Fulton Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 February 23 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Febry 16, 1930, to Febry 23, 1930, that I last saw h. alive on February 23, 1930, and that death occurred, on the date stated above, at 12.40 p.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon, M. D.

2/24. 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial: Feb. 26- 1930.

20 UNDERTAKER: Charles J. Schwab. ADDRESS 545 N. Monroe St.

tion should be carefully supplied. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 54414

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54414

CERTIFICATE OF DEATH.

REGISTERED NO. 1594

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 2830 Elliott st, Balto, md

CITY OF BALTIMORE: (NO. ST. 1-1 WARD)

2-FULL NAME Alvina Piechoecki

(a) RESIDENCE. NO. 2830 Elliott, Balto, Md WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): ✓

a If married, widowed, or divorced BUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days | If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Stephen Piechowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Bertha Smeak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Balto

14 Informant: Stephen Piechowski

(Address) 2830 Elliott st

15 Filed. , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-25 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-24, 1930, to 2-25, 1930.

that I last saw her alive on 2-25, 1930.

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Congenital umbilical defect with complete prolaps of the intestines 5 hours

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Infection (Peritonitis) 5 hours

(duration) yrs.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) Joseph Rosenblatt, M. D.

2/25, 1930 (Address) 3010 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: F. Hanselmann Cem. DATE OF BURIAL: Feb 25 1930

20 UNDERTAKER: Fisher & Fisher Undertakers ADDRESS 1000 Fremont

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

E 54415

E 54415

CERTIFICATE OF DEATH

REGISTERED NO. 27-53

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 Wyandanch ST. WARD

2—FULL NAME Andrew G. Schneider

(a) RESIDENCE NO. 700 Wyandanch ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of Katherine Schneider
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	57	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Store ✓

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) Bavaria
(State or country) Germany

PARENTS

10 NAME OF FATHER Geo Schneider

11 BIRTHPLACE OF FATHER (city or town) Bavaria
(State or country) Germany

12 MAIDEN NAME OF MOTHER Kathrina Reich

13 BIRTHPLACE OF MOTHER (city or town) Bavaria
(State or country) Germany

14 Informant Katherine Schneider
(Address) 700 Wyandanch Ave

15 Filed FEB 25 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930, to Feb 24, 1930, that I last saw him alive on Feb 24, 1930, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease

(duration) 7 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) A. Worthoff, M. D.

2/25 1930 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville (Evans)

DATE OF BURIAL 2/27 1930

20 UNDERTAKER D. J. Reck

ADDRESS 640 Saratoga

8-16-29—L. F. S.—100 Bks.

E 54416

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54416

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Harris

(a) RESIDENCE NO. 704 S. Hallas ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. Car.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 25 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24-30

17 I HEREBY CERTIFY That I attended deceased from Jan 28, 1930, to Feb 24, 1930, that I last saw her alive on Feb. 24, 1930 and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas involving left ovary & capsule

(Duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2/25, 1930 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Agnus Country. Not Catholic Cemetery

DATE OF BURIAL Feb 27-30

ADDRESS

20 UNDERTAKER Geo. L. Rust 1235 Harford Av

E 54417

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54417

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 912- N. Payson ST., 16-22 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Palmisano

(a) RESIDENCE NO. 912- N. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Palmisano

6 DATE OF BIRTH (month, day, and year) 5-27-1894

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	35	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Agnes Wheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Theo. Palmisano

(Address) 912- N. Payson

15 Filed FEB 25 1930 H. RAMSAY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 22/30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1929, to Feb 22, 1930, that I last saw h.. alive on Feb 22, 1930, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey M. D.

2/25, 1930 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 2/27/30 19

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hoffman

CAUSE OF DEATH TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54418

38 ✓ E 54418

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 285 Forrest St. St., 5-8 Ward)

2-FULL NAME Lucy Jones.(C)

(a) RESIDENCE NO. 285 Forrest St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): July 4, 1889.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	40	7	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Virginia
(State or country)

PARENTS

10 NAME OF FATHER: Jasper Butts.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Clara Bimley.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Virginia.

14 Informant: Ada Parker.(C) sister.
(Address): 610 S. Conway St.

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 20, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syphilis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Enquiry

(Signed) Otto M Eisenhardt M. D.

2/24. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

FEB 25 1930

THE MORGUE.

... & WOODALL

Cor. should be carefully supplied. Note space to be left blank. Exact statement of OCCUPATION is very important. See instructions on back of certificate. In deaths from violence, state whether it may be properly classified, so that it may be properly classified.

64

Cor.—10-16-29—A Co.—100 Bks.

E 54419

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54419

CERTIFICATE OF DEATH

101-001

11-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Friendly Inn.

City of Baltimore: (No. 809 S. Sharp St. St.) (Ward)

2-FULL NAME Henry Robinson. (C)

(a) RESIDENCE NO. 1218 Madison Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address) UNIV

15 Filed FEB 26 1930 Registrar

C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 9, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Enquiry

(Signed) Otto M. Reinhardt, M. D.

2/24, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

FEB 25 1930

THE MORGUE.

tion should be carefully supplied. Also answer No. 9 when possible. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-901 ✓ E 54420

REGISTERED NO. E 54420

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 5-8 Ward)

2-FULL NAME George Holmes.(C)

(a) RESIDENCE NO. 208 Colvin St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
✓	70	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Junk dealer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Virginia.
(State or country)

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Do not know.

14 Informant: George Burrell.(C)
(Address): 2209 Hunter St.

Filed FEB 25 1930 JAMES H. JONES, M. D. Registrar

By Kidd

438 THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 13, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary): Cerebral Apoplexy.

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? 208 Colvin st.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

2/24 1930 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS FEB 25 1930

Tion should be carefully supplied. Avoid using the general terms. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54421

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54421

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 26-32 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Wagner

(a) RESIDENCE NO. 804 S Fayley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Frank Wagner

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	35	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pittsburgh Pa

PARENTS

10 NAME OF FATHER Wlatz Bogdanski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Theodora Faust

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Frank S. Wagner
(Address) 804 S Fayley

Filed MAY 5 1930 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul T.B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) C. Lawson

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

What was an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

(Address) 1423 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL 5/26 1930

UNDERTAKER Wm. E. Fiaschetti

ADDRESS 1020 S Kenwood

tion should be carefully supplied. Avoid abbreviations. Write plainly with ink. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B 2

Spec.—8-16-29—L. F. S.—100 Bks.

E 54422

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54422

CERTIFICATE OF DEATH

1—PLACE OF DEATH Church Home - Infirmary REGISTERED NO. 69

CITY OF BALTIMORE: (No. Broadway ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. George C. Franklin

(a) RESIDENCE NO. 162 College Ave - Danville VA. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Danville Va.

PARENTS

10 NAME OF FATHER Acree C. Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lily M. Crawley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Danville Va.

14 Informant Acree C. Franklin (Address) 162 College Ave Danville

15 Filed ..., 19... Registrar

FEB 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1930, to Feb. 25, 1930, that I last saw h.live alive on Feb. 24, 1930 and that death occurred, on the date stated above, at 5.02 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 9 mos. da.

CONTRIBUTORY (Secondary) Generalized Carcinomatosis

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes (Exploratory Laparotomy) Date of Jan 22/30

Was there an autopsy? no

What test confirmed diagnosis? Operation.

(Signed) Vernon H. Norwood, M. D.

19 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Danville Va. DATE OF BURIAL Feb-26 1930

20 UNDERTAKER John C. Miller ADDRESS 2435 E Alyer

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54423 ✓ E 54423

CERTIFICATE OF DEATH. × 43

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE (No. Caton & Wilkens Ave ST. 75-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Charles Henry

2-FULL NAME Mary Melchior

(a) RESIDENCE NO. Gray Rock Ellicott City Md ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): March 10" 1869

7 AGE: 60 Years; Months 11; Days 14; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Carl Melchior

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Burkhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Sister - Mrs. Laura Schultz Gray Rock Ellicott City

15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-24— 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7th, 1930, to 2-24, 1930, that I last saw her alive on 2-24, 1930, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

2 Asphyxiation

- Suddenly -

(duration) yrs. mos ds.

1 CONTRIBUTORY (Secondary): Carcinoma tongue - mouth glands - neck (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home (Baltimore)

Did an operation precede death? yes Date of Aug 1929

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

Physician's Name & Address

3/7 (Signed) Fernando C. Fontana M. D.

1930 (Address) 904 W. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

20 UNDERTAKER: Joseph B Cook

DATE OF BURIAL: Feb. 27 1930

ADDRESS: 1003 W. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

25

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54424

CERTIFICATE OF DEATH.

31 E 54424

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospitals 4-26 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick W. Strunck

(a) RESIDENCE NO. 705 W. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Strunck

6 DATE OF BIRTH (month, day, and year) October 15, 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	59	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sign Painter

(b) General nature of industry, business, or establishment in which employed (or employer) $50

(c) Name of employer Jory and Co.

9 BIRTHPLACE (city or town) Philadelphia

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Mr. Strunck

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Holland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mr. Frederick A. Strunck

(Address) 705 W. Lexington Street

15 Filed C. HAMPSON JONES, M. D. Registrar

2 5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 24, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Put I B-

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Dr Lawshow

(duration) yrs. 1 ds.

(Signed) G. C. Gladus M. D.

(Coroner)

19 (Address) 143 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State 42 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Feb. 26 1930

20 UNDERTAKER Dept Cook ADDRESS 1003 West Baltimore

Don't should be carefully supplied. All blanks must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-16-29—L. F. S.—100 Bks.

E 54425

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 54425

CERTIFICATE OF DEATH

REGISTERED NO. 19-27

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr Chas. B. Goodman

(a) RESIDENCE NO. 1419 Edmonson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Bessie E. Goodman

6 DATE OF BIRTH (month, day, and year) July 9th 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm R. Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rebecca Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Mr Bessie E Goodman

(Address) 1419 Edmondson Ave

15 Medical Examiner C. HAMPSON JONES, M. D. Registrar

B 2 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1930, to Feb. 25, 1930, that I last saw him alive on Feb 25, 1930 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Hypertensive cardiovascular disease, with cerebral hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary adema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Samuel J. Helms, M. D.

2/25, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 2/28/1930

20 UNDERTAKER D. Wm Cook

ADDRESS 1217 St Paul St

important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 54426 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54426

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: No 5931 Belair Rd ST.; 26-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William M Miller

(a) RESIDENCE. NO. 5931 Belair ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Selina C Miller

6 DATE OF BIRTH (month, day, and year) July 6. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	61	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 60

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Works

9 BIRTHPLACE (~~city or town~~) (State or country) Penn

PARENTS

10 NAME OF FATHER James Miller

11 BIRTHPLACE OF FATHER (~~city or town~~) (State or country) Penn

12 MAIDEN NAME OF MOTHER Catharine Stalter

13 BIRTHPLACE OF MOTHER (~~city or town~~) (State or country) Penn

14 Informant James E Miller (Address) 2905 E Oliver

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

FEB 25 1930 Per AKB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Feb 28, 1930.

That I last saw him alive on Feb 28, 1930.

and that death occurred, on the date stated above, at 4.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebro Sclerosis

from history (duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C H Cruchang M. D.

Feb 27, 1930 (Address) 3108 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	2/26/1930

20 UNDERTAKER Wm Cook ADDRESS 127 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly CODED. ATTENTION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54427 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54427

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH — REGISTERED NO. 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (a) No. 2320 Greenmount Ave (b) St. (c) Ward

2-FULL NAME Benjamin C. Bennett

(a) RESIDENCE No. 2320 Greenmount Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE — Years: 76 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 966

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Stowe Vermont

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant (Address): Mrs James Wilson 2320 Greenmount

15 Died Feb 25, 1930 at 2 PM

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 1930 to Feb 25 1930

that I last saw h[illegible]ive on Feb 24, 1930

and that death occurred, on the date stated above, at 2 PM.

The CAUSE OF DEATH was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D L Packard M. D.

(Address) 1201 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crisfield Md — DATE OF BURIAL: 2/27/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

B 2 5 1930

TION is very important See instructions on back of certificate.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54428

E 54428

CERTIFICATE OF DEATH.

31

28-63

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4416 Belview ST. WARD)

2-FULL NAME Frank Prescott Woodhull

(a) RESIDENCE No. 4416 Belview ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 7 mos. ds. How long in U. S., if of foreign birth? Native mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Mary Baker Woodhull

6 DATE OF BIRTH (month, day, and year) Apr. 9-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Ship builder.

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) River Head Long Island, N. Y.

PARENTS

10 NAME OF FATHER Nelson S. Woodhull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Riverhead Long Island, N. Y.

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Riverhead Long Island, N. Y.

14 Informant Mrs. Mary B. Woodhull (Address) 4416 Belview Ave, Balto

15 C. HAMPSON JONES, M. D. Registrar

FEB 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25- 1930.

17 I HEREBY CERTIFY, That I attended deceased from July. 1927 to Feb. 25. 1930.

that I last saw him alive on Feby. 25. 1930.

and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows: Acute diarrhoea.

Years (duration) yrs. 4 mos.

CONTRIBUTORY (Secondary) A tubercular condition (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Contracted at place of death. X

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum & X ray.

(Signed) H. Hoffmeier M. D.

2-25-1930 (Address) 2500 Garrison Ave, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Riverhead Long Island N.Y.

DATE OF BURIAL Feby 28 1930

20 UNDERTAKER Harry R. Amacher X 4204 Ridgewood Ave

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54429

CERTIFICATE OF DEATH

24-001 V

E 54429

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1018 Madison Ave St., 11-24 Ward

2-FULL NAME Elias A. Cornish

(a) RESIDENCE NO. 1127 Norris St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Mary Della Cornish

6 DATE OF BIRTH (month, day, and year): Feb 2-1885

7 AGE: Years 45 | Months — | Days 21 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundry
(b) General nature of industry, business, or establishment in which employed (or employer): 870
(c) Name of employer: Bolte

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Mary Della Cornish
(Address) 1127 Norris

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Feb 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy) (duration) ... yrs. Sudden

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1018 Madison

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inspection

(Signed) H. Link, M. D.

19 23 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: 2-26 1930

UNDERTAKER: Samuel H. Hensley

ADDRESS 1378 W Baltimore

tion should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

825 1930

Spec.—1-30—M. & T.—250 Blks.

E 54430

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54430

CERTIFICATE OF DEATH.

REGISTERED NO. 4-25-90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME George Humphrey

(a) RESIDENCE NO. 439 Druid Hill Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 5-21-79

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Follows race horses

(b) General nature of industry, business, or establishment in which employed (or employer) 0 $6

(c) Name of employer

9 BIRTHPLACE (city or town) Jersey City
(State or country) N.J.

PARENTS

10 NAME OF FATHER John Humphrey

11 BIRTHPLACE OF FATHER (city or town) N.J.
(State or country)

12 MAIDEN NAME OF MOTHER Adeline ?

13 BIRTHPLACE OF MOTHER (city or town) N.J.
(State or country)

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

2 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24-30

17 I HEREBY CERTIFY, That I attended deceased from 2-14-30, 19..... to 2-24-30, 19.....,

that I last saw him alive on 2-24-30, 19.....,

and that death occurred, on the date stated above, at 6:10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 12 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic Senile

(duration) ..... yrs. 8 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

2-27, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 2/26 1930

20 UNDERTAKER Samuel K. Hensley

ADDRESS 1118 N Bdle St

CAUTION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 54431

E 54431

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1046 Stockton ST. 16-23 WARD

2-FULL NAME Maggie Whittaker

(a) RESIDENCE NO. 1046 Stockton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 If Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE: Years 47; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Wm Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Elkton

14 Informant: Joseph Whittaker (Address) 1046 N. Stockton St

15 Filed 2-5, 1930. C. HAMPSON JONES, M. D., Registrar. Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930, to Feb. 23, 1930.

that I last saw h[illegible] alive on 23rd Feb. 1930,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? I do not know

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Clifton Brown, M. D.

Feb. 1930 (Address) 1009 Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Peters Cem

DATE OF BURIAL 2/26 1930

20 UNDERTAKER: Samuel Stemley

ADDRESS 528 Biddle

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54432

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54432

CERTIFICATE OF DEATH

X 101-0

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alfred Cullen.

(a) RESIDENCE NO. Lutherville, Maryland ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Cullen

6 DATE OF BIRTH (month, day, and year) Mar 7, 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer Job-work

9 BIRTHPLACE (city or town) Balto Co., Md
(State or country)

PARENTS

10 NAME OF FATHER James C Cullen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah A Kitson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Co., Md

14 Informant Mrs. Alfred Cullen
(Address) Sutherville, Md

15 Filed C. HAMPSON JONES, M. D. Registrar
MAR 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1930, to Feb 25, 1930, that I last saw h~~e~~ alive on Feb. 25, 1930 and that death occurred, on the date stated above, at 2.05 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar, L. L. lobe.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Emphysema L. chest - c cardiac decompensation (duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 2-24-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy & operation

(Signed) Leroy L Hekler, M. D.

2-25-1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boden Cem, Cockeysville Md

DATE OF BURIAL Feb 28 1930

20 UNDERTAKER Wm. C. Burke & Son

ADDRESS Towson Md

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54433

CERTIFICATE OF DEATH

101-001

E 54433

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1120 Linden St. 41-24 Ward)

2-FULL NAME Mary Tate

(a) RESIDENCE NO. 1126 Linden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	1	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Rawlings Tate

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sadie Emory

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Sadie Tate
(Address) 1120 Linden St.

Filed FEB 26 1930 HAMILTON C. JONES, M. D. Registrar

4588

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ...(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) ... M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL FEB 25 1930

20 UNDERTAKER Undertaker Smith. — ADDRESS

tion should be carefully supplied. AGE should be stated [illegible] OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 54434

E 54434 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 24-001 E 54434

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 2627 Wilkens Ave. (ST.) 70-72 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Smith

(a) RESIDENCE NO. 2627 Wilkens Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry T. Smith

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS
10 NAME OF FATHER John B. Hayward
11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mr. Harry T. Smith
(Address) 2627 Wilkens Ave.

15 FEB 26 1930 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 23-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930, to Feb 23, 1930, that I last saw h-w alive on Feb 23, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) J Harry Slaughman, M. D.
Feb 27 1930 (Address) 2687 Wheeler Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Feb. 26/30

20 UNDERTAKER Harry T. Witzke ADDRESS 4101 Edmondson Ave.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54435

E 54435

CERTIFICATE OF DEATH.

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No.) Caroline & old (STREET OR AVENUE) (WARD)

2-FULL NAME Lonnie Cloud

(a) RESIDENCE NO. 1014 Sharp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Not Known

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	Not Known		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Yes

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not Known

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Virginia Cloud

(Address)

15 Filed FEB 26 1930 H. BRYSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24 1930.

17 I HEREBY CERTIFY, That I attended deceased from 2-20-30, 19..., to 2-24-30, 19...,

that I last saw h.. alive on 2-24-30, 19...,

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Septicaemia and Endocarditis (7) Unknown origin (1)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) J. W. Hundley M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL Jan 27 1930

UNDERTAKER E. L. Brown & Son

ADDRESS Vol. W. Mount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-001

E 54436

CERTIFICATE OF DEATH

E 54436

REGISTERED NO. E 54436

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Santa Lafata

(a) RESIDENCE NO. 376 Forrest St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	9	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Gaspard Lafata

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Patta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Gaspard Lafata

(Address) 376 Forrest St

15 Filed ..., 19... [illegible] Registrar

B 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to Feb. 27, 1930, that I last saw her alive on Feb. 24, 1930 and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Pharyngeal & Laryngeal Diphtheria

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Feb 24, 1930 Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron C. Lull, M. D.

2/25, 1930 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Feb 27 1930

20 UNDERTAKER Geo. L. Russ ADDRESS 1735 Harford a

important. See instructions on back of certificates.

Spec.—3-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54437

CERTIFICATE OF DEATH

3 1 ✓ E 54437.

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) ST 17-5D WARD)

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel Collins

(a) RESIDENCE NO. 2227 Barclay st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harold Collins

6 DATE OF BIRTH (month, day, and year) 1897 - Nov 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	32	3.	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER J.S.Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Catherine Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed FEB 25 1930 19 C. RAMSAY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 22, 1930, to Feb. 25, 1930, that I last saw her alive on Feb. 25, 1930 and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Arnold Jr. M. D.

2-25. 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Point Va

DATE OF BURIAL Feb 28 1930

20 UNDERTAKER Mrs. J. W. Teufel & Son

ADDRESS 801 W. Fayette

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—800 Blks.

E 54438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54438

CERTIFICATE OF DEATH

REGISTERED NO. 31

1—PLACE OF DEATH Baltimore City Hospitals (Inc.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 30-69 WARD

2—FULL NAME John W. Smith

(a) RESIDENCE NO. 411 E. Lynn st. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Smith

6 DATE OF BIRTH (month, day, and year) July 30, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	33	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 023

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara Poff

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 FEB 26 1930 C. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1930, to Feb. 24, 1930, that I last saw h im alive on Feb. 24, 1930 and that death occurred, an the data stated above, at 1.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place af death? Unknown

Did an operation preceda death? No Date af

Was thera an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos Schwab M. D.

2-24 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, ar in deaths from Violent Causes, state (1) Means and Nature af injury, and (2) whether Accidental, Suicidal ar Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Feb. 27 1930

UNDERTAKER George L. Schwab

ADDRESS 2101 Eutk. ave.

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54439 E 54439

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) Carlton & Olney 23-48 WARD

2-FULL NAME Levi Thompson

(a) RESIDENCE NO. 1668 Kerwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie P. Thompson

6 DATE OF BIRTH (month, day, and year) Sept 17, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Balto City Stone 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo R Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Ellen Dement

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Hattie P. Thompson (Address) 133 E Northern

15 Filed [illegible] 19 [illegible] Registrar

B 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-25 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-8-30, 19..., to 2-25-30, 19..., that I last saw h alive on 2-25-30, 19..., and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia & Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) W. M. Handley M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL July 28 1930

20 UNDERTAKER John Merrick

ADDRESS 2008 Bloom

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54440

CERTIFICATE OF DEATH

124 E 54440

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3600 E Lombard ST. 46-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Bauer

(a) RESIDENCE NO. 3600 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Bauer

6 DATE OF BIRTH (month, day, and year) July 26 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 18 years

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Herman Bauer

(Address) 3600 E Lombard

15 Filed 2 6 1930, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24/1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1- 1929, to Feby 24- 1930, that I last saw h alive on Feby 23 1930 and that death occurred, on the date stated above, at 11 07 a.m.

The CAUSE OF DEATH* was as follows:

chronic cholecystitis.

chronic urinary cystitis (Bladder stone)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Oedema. Cardiac dilatation (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms. X Ray.

(Signed) Allen C. Beetham, M. D.

2-25, 1930 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Feby 27 30

20 UNDERTAKER John Ellrich

ADDRESS 2018 Allens

important. See instructions on back of certificates.

BB

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54441

CERTIFICATE OF DEATH

E 54441

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1682 Darley Ave St. 8-45 WARD)

2—FULL NAME John Stock

(a) RESIDENCE NO. 1682 Darley Ave St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie A Stock

6 DATE OF BIRTH (month, day, and year) Oct 22/1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker.

(b) General nature of industry, business, or establishment in which employed (or employer) 003

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Marie A Stock
(Address) 1682 Darley Ave

15 HAMPSON JONES, M. D. Registrar

FEB 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24/1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930, to , 19 ,
that I last saw h alive on Feb. 24 30, 19
and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Val. dis. Heart,

Duration Yrs. Mos. Da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm T. Peters, M. D.

Feb 26, 1930 (Address) 839 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Feby 27 1930

20 UNDERTAKER John Merritt

ADDRESS 20 S Bway

Important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—000 Bks.

E 54442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 54442

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 S. Gilmor ST., 19 WARD) 1928

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Healey

(a) RESIDENCE NO. 132 S. Gilmor ST., 19 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Centenarian

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Maher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary E. Lowman

(Address) 137 S. Gilmor st

15 Filed MAR 26 1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25/30

17 I HEREBY CERTIFY, That I attended deceased from 2-23-30, 19, to 2-25, 1930, that I last saw h alive on 2-25-30, 19, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) [illegible] yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Bernard Terry, M. D.

2/25/1930 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL March 28 1930

20 UNDERTAKER A. Jones — ADDRESS N. S. Gilmor

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54443

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54443

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 77-33

CITY OF BALTIMORE: (No. 18 E, Henrietta ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John O. Longo

(a) RESIDENCE NO. 18 E, Henrietta ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Baby

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) Jan, 27, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4		28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Domenico Longo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosaria Barranco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Santo Barranco

(Address) 427 E, Fort, Ave

15 Filed ... 19... CLAMPITT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 23 -, 1930, to Feb 25, 1930

that I last saw h[illegible] alive on Feb 25, 1930

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C. W. Norden, M. D.

, 19 (Address) 857 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Feb 27 1930

20 UNDERTAKER Frank V. Petrone ADDRESS 2818 E, Balto St

important. See instructions on back of certificates.

FEB 26 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54444 74-001 E 54444

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital St. 3-4 Ward)

2-FULL NAME Alex Kodenski

(a) RESIDENCE NO. 1614 Eastern Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE~~ of Maleya Kodenska

6 DATE OF BIRTH (month, day, and year) Not. Known

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	45	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) B-O-R R. Co
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Polanes

PARENTS

10 NAME OF FATHER Not. Known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Maleya Kodenska
(Address) 1614 Eastern

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to his death (Inquest, autopsy or inquiry)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory Arteriosclerosis (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. C. Gladden, M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	2/2 1930
20 UNDERTAKER	ADDRESS
W. Gawronski	1618 Eastern

E. HERMAN LOMS, M. D.

FEB 26 1930

tion should be carefully supplied. AGE should be stated EXACTLY. Prefession or OCCUPATION is very important. See instructions on back of certificate. DEATH in plain terms, so that it may be properly classified. Exact statement of

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54445 129 ✓ E 54445

E 54445

CERTIFICATE OF DEATH

REGISTERED NO. 27453

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 Keene Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie B. Strauss

(a) RESIDENCE NO. 3411 Keene Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 11 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Strauss

6 DATE OF BIRTH (month, day, and year) Mar. 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Beidebach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Acton (daughter)

(Address) 3411 Keene Ave

15 [illegible] HAMPSON JONES, M. D. Registrar

FEB 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929 to Feb 24, 1930

that I last saw h[illegible] alive on Feb 23, 1930

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(duration) mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hawkins, M. D.

2/26 1930 (Address) 1 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 2/27 1930

20 UNDERTAKER J. Frew McCully

ADDRESS 130 E. Fort

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54446

CERTIFICATE OF DEATH

162

E 54446

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Hollins ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Albert Wright

(a) RESIDENCE NO. 1602 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Harry C. Wright

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Marie Hillis

13 BIRTHPLACE OF MOTHER (city or town) Salem N. J.
(State or country)

14 Informant Catherine Marie Wright
(Address) 1602 Hollins St

15 Filed FEB 25 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1930, to Feb. 25, 1930

that I last saw h[illegible]alive on Feb. 25 1930

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum — Life (duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. C. L. Cunningham M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Feb 26 1930

20 UNDERTAKER John A. Denny — ADDRESS 715 Light St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54447

CERTIFICATE OF DEATH.

E 54447

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No.) 1000 Eaton Ave ST. 15-61 (WARD)

2-FULL NAME George W. Edwards

(a) RESIDENCE NO. 6611 Wendover Hall Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adelaide H. Edwards

6 DATE OF BIRTH (month, day, and year): March 24 1853

7 AGE: Years 76 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Emory L. Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Jenkins Memorial Hospital

(Address) 1000 Eaton Ave

15 Filed FEB 26 1930, HAMILTON JONES, M. D. Registrar

by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-30, 1929, to 2-24, 1930, that I last saw him alive on 2-24, 1930, and that death occurred, on the date stated above, at 9.50 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) gangrene left foot

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Feb 27 1930

20 UNDERTAKER: George J. Smith

ADDRESS 1537 Hollins

CAUSE OF DEATH to plain print, as shown in sample. TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54448 ✓

E 54448

CERTIFICATE OF DEATH

REGISTERED NO. ____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. ST. H-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm Burkett Beares.

(a) RESIDENCE NO. Elk Ridge, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	17	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur & Driver

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Harry Beares

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. Md (State or country)

12 MAIDEN NAME OF MOTHER Margaret Vinyard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)

14 Informant Mrs. Margaret Beares

(Address) Elk Ridge. Md.

15 Filed ... 19 ... Registrar

B 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/25/30.

17 I HEREBY CERTIFY, That I attended deceased from 2/22/ 19 30., to 2/25 19 30.

that I last saw h im alive on 2/24 19 30.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia bilateral

(duration) ... yrs. ... mos. 2/ ds.

CONTRIBUTORY (Secondary) Empyema, bilateral.

(duration) ... yrs. ... mos. 0 ds.

18 Where was disease contracted if not at place of death? Same.

Did an operation precede death? Yes Date of 2/25/30

Was there an autopsy?

What test confirmed diagnosis? Clin., x-ray & operation

(Signed) Henry T. Mallett, M. D.

19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL March 1, 1930

20 UNDERTAKER E. LeRoy Stiffler, Inc

ADDRESS 125 E. North Ave.

IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54449

CERTIFICATE OF DEATH

188-002

E 54449

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lodie Helm

(a) RESIDENCE NO. 3403 O'Donnell St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Helm

6 DATE OF BIRTH (month, day, and year) April 11-1887

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Skilled Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 840
(c) Name of employer Balto. City

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER J. Geo. Helm

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Charlotte Pabst

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Theresa Helm
(Address) 3403 O'Donnell

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

St 6 as ucc

Traumatic Amp. both Legs

(duration) yrs. mos. Shr ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Surgical Evidence

(Signed) J C Fiddes, M. D.

19 (Address) 143 W Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL Feb 28 1930

20 UNDERTAKER George W. Zirkle

ADDRESS 1737 E. Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

B 54450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 ✓ E 54450

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 1637 Ward)

2-FULL NAME Albert J Hotter

(a) RESIDENCE NO. 511 S-47 St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dorothy E Weber

6 DATE OF BIRTH (month, day, and year) Aug 11-1910

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	19	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Weber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Catherine Geigel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Catherine Weber
(Address) 511 S. 47th St.

15 Filed ....., 19.... HAMILTON JONES, M. D. Registrar

FEB 26 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide
Gun Shot wound of Head
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) G C Glades, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn cemetery

DATE OF BURIAL Feb 27 19 30

20 UNDERTAKER George W. Zibler

ADDRESS 1737 E. Eager

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54451

CERTIFICATE OF DEATH

E 54451

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 106 N. Highland St., 76-11 Ward)

2-FULL NAME Katherine Bayer

(a) RESIDENCE NO. 106 N. Highland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Bayer

6 DATE OF BIRTH (month, day, and year) May 8-1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
✓	72	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Peacock

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Frances Adelman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Dorothy Bayer
(Address) 106 N. Highland Ave

15 FEB 26 1930 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acc fall in house
Fracture of R. Thigh
(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) G. C. Wade, M. D.
19 (Address) 1426 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Feb 28 1930

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager

Information should be carefully supplied. AGE should be stated EXACTLY. Particularly is exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54452

CERTIFICATE OF DEATH

31

E 54452

1—PLACE OF DEATH Univ. Hospital REGISTERED NO. 2580

CITY OF BALTIMORE: (No. Lombard & Greene STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonard Logan.

(a) RESIDENCE NO. 533 W. Baltimore St. STREET Boarding house. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE: 18 | Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER Arronn Logan.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Pauline Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant

(Address)

15 Filed FEB 26 1930 1389 Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/23/30

17 I HEREBY CERTIFY, That I attended deceased from 1/11/30, 19, to 2/23/30, 19, that I last saw him alive on 2/23/30, 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Tuberculous Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Ex. X Ray.

(Signed) Luther E. Elliott M. D.

, 19 (Address) 2 E. Lille

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health — ADDRESS FEB 26 1930

THOS. HAMPSON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54453

CERTIFICATE OF DEATH

161-002

E 54453

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6 Merryman Court ST. Druid Park WARD)

2—FULL NAME Eleanora Macsherry

(a) RESIDENCE NO. 6 Merryman Court ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 26 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Clinton Macsherry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Marion Shivers

13 BIRTHPLACE OF MOTHER (city or town) Union Mills (State or country) Carroll Co Md

14 Informant Clinton T Macsherry

(Address) 6 Merryman Court

15 FEB 26 1930 19 H. M. [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from — 19 . to Feb 26th 1930, that I last saw h alive on Infant — " 19 30 and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Intrapartum Asphyxia —

10 minutes —
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) knot in umbilical Cord

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical —

(Signed) Hugh W. Brent M. D.

19 (Address) 16 E Chase St —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Feb 26 1930

20 UNDERTAKER Keeney & Parkin Sons

ADDRESS McCulloh & Orchard Sts

OF DEATH in plain terms, so that it may be properly classified. Date entered. Please write very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54454

CERTIFICATE OF DEATH

129 ✓

E 54454

REGISTERED NO. 7-56

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital, WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Long

(a) RESIDENCE NO. 3308 Dupont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 1 mos. 24 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1917

7 AGE	Years	Months	Days 23	If LESS than 1 day, hrs. or min.
✓	13	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Long

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rena Luccile

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Charles Long

(Address) 3308 Dupont Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1930 to Feb 24, 1930

that I last saw h alive on Feb 21, 1930

and that death occurred, on the date stated above, at 11.25 p. m.

The CAUSE OF DEATH was as follows:

Myocardial insufficiency

Pneumonitis—

Nephritis— 5 weeks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3308 Dupont Ave

Did an operation precede death? No Date of

Was there an autopsy? No Clinical findings

What test confirmed diagnosis?

(Signed) J. B. Fischer M. D.

Per Hardy Pinnstaff

Feb 24, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Feb 27, 1930

20 UNDERTAKER Harry L. Nitzke ADDRESS 4101 E. Lombard Ave.

MARK DEATH in plain terms, so that it may be properly classified. Each statement is important. See instructions on back of certificates.

FEB 26 1930 H. HARRISON JONES M.D.

Spec.—1-10-21 M&T 1500 Blks.

E 54455

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54455

84 E 5445.7

CERTIFICATE OF DEATH.

REGISTERED NO. 77-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2704 Rogers Ave ST., 27 WARD

2-FULL NAME Katherine Ray.

(a) RESIDENCE No. 2704 Rogers Ave ST., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE: Years 66; Months; Days 11; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna

PARENTS

10 NAME OF FATHER: George Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Kath. Ray

(Address): 2704 Rogers Ave

15 Filed: FEB 26 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Feb 26th, 1930, that I last saw h[illegible] alive on Feb 26th, 1930 and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans Chronic

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Uraemic Poisoning (Coma) (duration) yrs. 5 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual Clinical

(Signed) Sherman R. Ward, M. D.

3/26 1930 (Address) 2601 Manhattan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa

DATE OF BURIAL: 2-27 1930

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Penna

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

001 ✓

E 54456

CERTIFICATE OF DEATH

100 E 54456

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 754 W Franklin ST. 17-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Freeland

(a) RESIDENCE NO. 754 W Franklin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5y yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: annie Freeland

6 DATE OF BIRTH (month, day, and year): 1872

7 AGE: Years 58 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James Freeland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: annie Freeland

(Address) 754 W Franklin St

15 Filed FEB 26 1930 WILLIAM H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930, to Feb 24, 1930, that I last saw h[illegible] alive on Feb 24, 1930 and that death occurred, on the date stated above, at 1 20 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia-Hypostatic

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [signature], M. D.

. 19 (Address) 753 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 2-27 1930

20 UNDERTAKER: Dennis Easton

ADDRESS: Balto Md

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54457 — CERTIFICATE OF DEATH. — 113 — E 54457

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 136½ (Street) Clement (Ward) 24-33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amy May Gatton

(a) RESIDENCE NO. 1308 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Sept 14/1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	5 6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jno W. Gatton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amy Dill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jno W. Gatton

(Address) 1308 Williams St

Filed FEB 26 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Feb 25, 1930, that I last saw h alive on Feb 25 1930, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH was as follows:

Bronchial Pneumonia

(duration) 1 yrs. 1 mos. 8 da.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 4 da.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harper, M. D.

, 19 (Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 2/27 1930

20 UNDERTAKER Philips, Herwig

ADDRESS 2066 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 54458 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 100 E 54458

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 315 S Ann ST. 7-4 WARD)

2-FULL NAME John. Lewandowski

(a) RESIDENCE NO. 315 S Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 2-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Felix Lewandowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Walerja Puka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John. Lewandowski

(Address) 315 S Ann St.

15 [illegible] C. HAMPSON JONES, M. D. Registrar

FEB 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb-25, 1930, to Feb-25, 1930.

that I last saw him alive on Feb 25, 1930

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Exhaustion.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John W Wade M. D.

, 19 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery — DATE OF BURIAL Feb 27 1930

20 UNDERTAKER George A. Weber — ADDRESS 705 S Ann St

NOTE.—WHITE PAPER must be used. AGE should be stated EXACTLY. PHYSICIANS and others should be carefully supplied

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54459

CERTIFICATE OF DEATH

66 E 54459

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1616 Olive St. St. 8-17 Ward)

2-FULL NAME Delia C. Wise.

(a) RESIDENCE NO. 1616 Olive St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ——— mos. ——— ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White.	Married

5a If married, widowed or divorced (or) WIFE of William Wise.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	51	———	———	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D.C.
(State or country)

PARENTS

10 NAME OF FATHER Patrick Ganley.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Joseph J. Hirsch. (son)
(Address) 834 William St.

B 2 6 1930 C. HAMPSON JONES, M.D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 23, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry

(Signed) Otto M. Steinhardt, M. D.

2/24. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A. A. C	Feb. 27 1930
20 UNDERTAKER	ADDRESS
Margaret D. Hynes	1422 Eighth St.

B—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

234E 54460 — E 54460

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rex Springston

(a) RESIDENCE NO. 532 W 2nd St ST., WARD Weston W Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zella Springston

6 DATE OF BIRTH (month, day, and year) Jan 26 1885 Linterown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	45	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Preston Spring

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Helen Baily

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar Per

3 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930, to Feb 26, 1930

that I last saw h.. alive on Feb 26, 1930

and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Acoustic neuroma, Left (Benign)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation with removal of tumor

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/25/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Clarence B Gardner M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Preston W. Va	Feb 26 1930

UNDERTAKER Chas F. Rowe & Son ADDRESS 1011 W Mt Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54461

101-001

E 54461

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2003 Cedley ST. 25th WARD 37)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Loretta June Hamm

(a) RESIDENCE NO. 2003 Cedley ST., 25th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 20, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓		8	5 4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas. Hamm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hylwella N.J.

12 MAIDEN NAME OF MOTHER Francis Kaufman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Chas. Hamm

(Address) 2003 Cedley St.

15 C. HAMPSON JONES, M. D. Registrar

EB 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1930, to Feb 25, 1930, that I last saw her alive on Feb 25, 1930 and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.
(Rt. Lower)

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Acute Bronchitis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H. Thomas Wheeler M. D.

2/26, 1930 (Address) 2910 Hollins Ferry Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gar. Lawn Cem.

DATE OF BURIAL Feb 28, 1930

UNDERTAKER Josiah Syfer

ADDRESS 1600 W. North Ave

OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION IS very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54462 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54462

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5-8 ST.) (WARD)

2-FULL NAME Anton Hirshauer

(a) RESIDENCE NO. 207 N. High St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

6 DATE OF BIRTH (month, day, and year) Aug. 22, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	48	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Victor E. Hirshauer

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country)

12 MAIDEN NAME OF MOTHER Teenie Schimek

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

14 Informant Records of (Address) Balto. City Hosp.

15 Filed FEB 20 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-24-30

17 I HEREBY CERTIFY, That I attended deceased from 2-18-30, 19..., to 2-24-30, 19...,

that I last saw h im alive on 2-24-30, 19...,

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic Acute

(duration) yrs. 4? mos ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) yrs. 4? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McKean, M. D.

2-25, 1930 (Address) Balto. City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 2/27 1930

20 UNDERTAKER J J Moran

ADDRESS 3000 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT RESIDENCE must be given. DEFINITE LOCATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54463

CERTIFICATE OF DEATH.

161-00 ✓ E 54463

1-PLACE OF DEATH

City of BALTIMORE: (No. 210 E. Randall St. 24-34 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant son of Mr. & Mrs. Edward Rickards

(a) RESIDENCE NO. 210 E. Randall St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or race: White

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb. 25, 1930

7 AGE — Years | Months | Days | IF LESS than 1 day 14 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. (State or country): Md

PARENTS

10 NAME OF FATHER: Edward Rickards

11 BIRTHPLACE OF FATHER (city or town): (State or country): Md

12 MAIDEN NAME OF MOTHER: Pleasant Frey

13 BIRTHPLACE OF MOTHER (city or town): (State or country): Virginia

14 Informant: Mrs. Edward Frey

(Address) 210 E. Randall

15 Filed ....., 19 ..... Registrar

526 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: Feb. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1930, to Feb. 26, 1930

that I last saw h. alive on Feb. 26, 1930

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Abnormal Presentation

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Mechanical Pressure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted —

If not at place of death! —

Did an operation precede death! No Date of .....

Was there an autopsy! No

What test confirmed diagnosis? Clinically

(Signed) H. E. K. Campbell M. D.

2/26 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. Frederick Date of Burial: Feb 27 1930

20 UNDERTAKER: A. Howard Evans ADDRESS: 38 E Fort Ave

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates. AGE should be carefully supplied. AGE should be stated EXACTLY.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54464

90 E 54464

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 11-24 WARD)

2—FULL NAME Mr Frank Wentworth

(a) RESIDENCE NO. 43 W Preston St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	60 yrs +			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 024

(c) Name of employer J. Lewston Co

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Electrical Local # 28

(Address) 1222 St Paul St

15 Filed 3 26 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/15, 1930, to 2/26, 1930, that I last saw h[illegible] alive on 2/26, 1930 and that death occurred, on the date stated above, at 2:10 a m.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis and chronic suppurative

Several years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) W. P. Elgin, M. D.

2/26, 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet New Jersey	2/26 1930
20 UNDERTAKER Uhlein Cook	ADDRESS 127 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

3 26 1930

Cor.—10-10-29—A Co.—100 Bks.

E 54465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓ E 54465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 3-4 Ward)

2-FULL NAME Angelina Venditti

(a) RESIDENCE NO. 1513 Bank St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30-1929

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
		2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Louis Venditti

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Catherine Weiletska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Wendall Dipple
(Address)

15 Filed ... 19...

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia-Dehydration

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ... M. D.

19 2/26/30 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem.

DATE OF BURIAL Feb 26 1930

20 UNDERTAKER Wendell J Dippel

ADDRESS 300 S Eden St

FEB 26 1930

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54466

CERTIFICATE OF DEATH

90

E 54466

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 S. Ann St. ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julian Wieprecht

(a) RESIDENCE NO. 234 S. Ann St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	74	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 640

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Wieprecht

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Suska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) poland

14 Informant Mary Kawalska

(Address) 234 S. Ann St.

Filed B 2 6 1930 C. HAMPSON JONES, M. D. Registrar

By: MCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 5, 1930, to Feby 24 1930, that I last saw h[illegible] alive on Feby 24 1930 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows: Cardiac Asthma

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Sym

(Signed) Jas L. Hooper, M. D.

2/26 1930 (Address) 962 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL Feb 28 1930

20 UNDERTAKER John W. Wetzel

ADDRESS Chester

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54467 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 ✓ E 54467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2617 Pennsylvania Ave. WARD) 12 59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Beele Meister

(a) RESIDENCE NO. 2617 Pennsylvania Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J. Meister

6 DATE OF BIRTH (month, day, and year) May 11, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	47	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond. (State or country) Va.

PARENTS

10 NAME OF FATHER John Rodgers.

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va

12 MAIDEN NAME OF MOTHER Alice Hopkins

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va.

14 Informant Edward J. Meister (Address) 2617 Penna Ave.

15 Filed FEB 27 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 19 25, to Feb 25, 19 30, that I last saw her alive on Feb 25, 19 30, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. Lloyd, M. D.

, 19 (Address) 1737 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Feb. 27 1930

20 UNDERTAKER Wm. J. Hickner Sons

ADDRESS North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important. See instructions on back of certificates.

EB 27 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 54468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 54468

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fred Barnes

(a) RESIDENCE NO. 1312 N Bradford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Cl	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Barnes

6 DATE OF BIRTH (month, day, and year) 1877 Feb 7

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Preacher

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lydia Barnes

(Address) 512 N. Bradford

15 Filed FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/24/30

17 I HEREBY CERTIFY, That I attended deceased from 1-26, 1930, to 2-24, 1930, that I last saw h alive on 2-24, 1930 and that death occurred, on the date stated above, at 10.55 P. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension and Prostate

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) B Barnes, M. D.

19 30 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington

DATE OF BURIAL 2-27 1930

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Lemmon Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54469

CERTIFICATE OF DEATH.

E 54469

1-PLACE OF DEATH Hutchins Home Hosp

CITY OF BALTIMORE: (No. 418 Huntsman Ave ST. 27-48 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ena Cannella

(a) RESIDENCE NO. 418 Huntsman Ave ST., 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Cannella

6 DATE OF BIRTH (month, day, and year): May 10-1870

7 AGE: 59 Years 9 Months 14 Days

If LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): Home work

(c) Name of employer: no

9 BIRTHPLACE (city or town) (State or country): Campbell Mo

PARENTS

10 NAME OF FATHER: Unknown Surgey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ampbell Mo

12 MAIDEN NAME OF MOTHER: Susan Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mo

14 Informant (Address): Emma Cannella 418 Huntsman Ave

15 Filed FEB 27 1930 G. HARRISON JONES, M. D. Registrar Per KW

B 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1930 to Feb 24, 1930, that I last saw h alive on Feb 24, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Hemorrhagic

(duration) 1 yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary): Chronic Valvular & Rheumatic

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) Dr H B Benson, M. D.

Feb 26, 1930 (Address) 601 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fern Cemetery Ferndale

DATE OF BURIAL: Feb 27 1930

UNDERTAKER: Mrs. H. A. Ellicott

ADDRESS: 1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54470
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 E 54470
REGISTERED NO.

City of BALTIMORE: (No. 4719 Parkhurst St., 2-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter M Dalfner

(a) RESIDENCE NO. 4719 Parkhurst St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Winona V. Dalfner

6 DATE OF BIRTH (month, day, and year): Nov 17 1855

7 AGE: Years 71 Months 3 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): 045
(c) Name of employer

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER: Adolphus Dalfner
11 BIRTHPLACE OF FATHER (city or town): Germany
(State or country)
12 MAIDEN NAME OF MOTHER: Winona Curtis
13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Mrs W. M. Dalfner
(Address) 4719 Parkhurst St

C. HAMILTON JONES, M. D.
Registrar

Filed FEB 27 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Calculus
Disease of Heart
(duration) ...yrs. ...mos. ...ds.
CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

(Signed) J. L. Norris M. D.
(Coroner)
2-27 1930 (Address) 1632 N. Lamdon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ...yrs., ...mos., ...ds. In the State ...yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Date of Burial: Feb 27 1930
20 UNDERTAKER: A. S. Marshall ADDRESS: 3539 Fallsway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54471 — 129 ✓

CERTIFICATE OF DEATH

REGISTERED NO. E 54471

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 S Ellwood ave ST., 1 WARD)

2—FULL NAME Anna E Jubb

(a) RESIDENCE NO. 812 S. Ellwood ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Jubb

6 DATE OF BIRTH (month, day, and year): Aug. 1845

7 AGE: Years 84 | Months 6 | Days | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: James Riggins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ire.

12 MAIDEN NAME OF MOTHER: Mary O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ire.

14 Informant: Miss Mary Jubb

(Address) 812 S. Ellwood ave

15 Filed ... 19 ... Registrar

16 DATE OF DEATH (month, day, and year): Feb. 25 30

17

I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1930, to Feb. 25, 1930, that I last saw h.. alive on Feb. 20, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

Chr. Nephritis

(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary): Debility Days.

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? C

(Signed) T. Joseph Tawney, M. D.

, 19 (Address) 800 S Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: March 1930

20 UNDERTAKER: John A Moran

ADDRESS: 3000 E Pratt St

OF DEATH in plain terms, so that it may be properly classified. Use additional sheet if necessary. Be sure to answer all questions. Items are important. See instructions on back of certificates.

FEB 27 1930

H. D. 'M. SIMMONS-SMITH, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54472

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54472

CERTIFICATE OF DEATH

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3147 Fredk ave ST. 20-70 WARD)

2—FULL NAME Anna Barbara Wagner

(a) RESIDENCE NO. 3147 Fredk ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wagner

6 DATE OF BIRTH (month, day, and year) April 4th 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

031

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schwinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna B. Grellen

(Address) Ridgewood P. Relay P. O.

15 Filed FEB 27 1930, 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26/30

17 I HEREBY CERTIFY, That I attended deceased from Oct 2, 1928, to July 26, 1930, that I last saw her alive on July 25, 1930 and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows: Chron Interstit Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension Coron

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no (Clin. Anat)

What test confirmed diagnosis? —

(Signed) Gustav Dill, M. D.

2/27, 1930 (Address) 1433 N Loudon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Feb. 28th 1930

20 UNDERTAKER Charles W. Dill

ADDRESS 3109 Fredk. Ave.

DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

important.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54473

74-001

CERTIFICATE OF DEATH

E 54473

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 715 N. Bruce ST. 16-27 WARD)

2—FULL NAME Sarah Payne

(a) RESIDENCE NO. 715 N. Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Payne

6 DATE OF BIRTH (month, day, and year) June 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cowdenspell

PARENTS

10 NAME OF FATHER Abraham Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Benj. Payne

(Address) Elkridge

15 Filed FEB 27 1930, 19 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27/30

17 I HEREBY CERTIFY, That I attended deceased from 2/17, 1930, to 2/27, 1930, that I last saw h[illegible] alive on 2/26, 1930 and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 10 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. N. Pigott, M. D.

2/27 1930 (Address) 1536 W. Lafayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Feb 28 1930

20 UNDERTAKER Clarence E. Wright

ADDRESS Catonsville Md

OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54474

CERTIFICATE OF DEATH

REGISTERED NO. E 54474

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3316 N. Calvert ST. 12-49 WARD)

2—FULL NAME Eliza Temperance Britton

(a) RESIDENCE NO. 3316 Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

3a If ~~single~~, widowed, ~~or divorced~~
(or) WIFE of Edgar B. Britton

6 DATE OF BIRTH (month, day, and year) October 2. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	76	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Millington
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Money

11 BIRTHPLACE OF FATHER (city or town) Kent Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Robertson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

14 Informant Mrs Mable LaRoque
(Address) 330 Tunbridge Road

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1929, to Feb. 25, 1930, that I last saw h[illegible] alive on Feb. 25, 1930 and that death occurred, on the date stated above, at 9:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial tuberculosis

(duration) [illegible] yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bacillus pneumonia.

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) W. B. Cunningham M. D.

2/27, 1930 (Address) 626 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Millington Md.

DATE OF BURIAL
Feb 28 1930

20 UNDERTAKER Strycker Jones Inc

ADDRESS
424 N. Broadway

FEB 27 1930

OF DEATH in plain terms, so that it may be of property classified. Exact information is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54475

CERTIFICATE OF DEATH

E 54475

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4808 Palmer Ave. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James L. Footen

(a) RESIDENCE NO. 4808 Palmer Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 6 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Footen

6 DATE OF BIRTH (month, day, and year) July 31st 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Installer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer C & P Telephone Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER, Thomas Footen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Casey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Mary A. Footen (Address) 4808 Palmer Ave.

15 Filed FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 23 19 29 to Feb 24 19 30, that I last saw him alive on Feb 23 19 30 and that death occurred, on the date stated above, at 11 35 P. m.

The CAUSE OF DEATH* was as follows:

Tumors of Brain (Cerebral)

CONTRIBUTORY (Secondary) E. Laudrin (duration) 1 yrs. 2 mos. da.

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 8 29

Was there an autopsy? No

What test confirmed diagnosis? Oper

(Signed) J. C. Eadus, M. D.

19 (Address) 4306 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 2/28/1930

20 UNDERTAKER John J. Howard & Son.

ADDRESS 908 Hollins St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

23 E 54476 — 59 V 003 — 1 59 E 54476

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 18-16 WARD)

2—FULL NAME George Hunnicutt

(a) RESIDENCE NO. 2236 Carrollton ST. Ave WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31-1929

7 AGE: Years / Months 1 mths Days 26 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER George Huntingutt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md —

12 MAIDEN NAME OF MOTHER Clara Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Conn —

14 Informant: Rel'd —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed FEB 27 1930 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 26, 1930, that I last saw h[illegible] alive on Feb 26, 1930 and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Cystic stenosis and Intracranial

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. O. Y. Warren, M. D.

2/27 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. — DATE OF BURIAL: 2/28th 1930

20 UNDERTAKER: John F. Howard & Son. — ADDRESS: 908 Hollins St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54477

CERTIFICATE OF DEATH

109-002 E 54472

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 527 S Longwood ST., 10-10 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leroy Luther Kautsch

(a) RESIDENCE NO. 527 S Longwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17 1930

7 AGE: Years — Months 1 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) nil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harry N Kautsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Lydia Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry N Kautsch

(Address) 527 S Longwood St

15 Filed FEB 27 1930 WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-25-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1930, to Feb 25, 1930, that I last saw him alive on Feb 25 1930 and that death occurred, on the date stated above, at 1047 P m.

The CAUSE OF DEATH* was as follows:

Follicular tonsilites

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) Fred T Lepper, M. D.

, 19 (Address) 3321 Fredt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Victrtsville

DATE OF BURIAL 2-27 1930

20 UNDERTAKER Mrs Chas A. G. Rohde 2327

ADDRESS Edmondson

OF DEATH if plain letters, so that it may be properly important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54478

CERTIFICATE OF DEATH

75 E 54478

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Ausguth ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Brinnige

(a) RESIDENCE NO. 207 Ausguth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	C	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Mrs Mary Handy

(Address) 207 Ausguth St

15 Registered FEB 27 1930 H. AMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 18 1930 to Feb 25 1930, that I last saw her alive on Feb 25 1930 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 8 da.

CONTRIBUTORY (Secondary) no

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Louise F Allen M. D.

Feb 28 1930 (Address) 608 Fawn St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem.

DATE OF BURIAL 2-27 1930

20 UNDERTAKER Byron & Wright 1218 Madison St

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Label statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10 1-001 E 54479

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1808 N. Bond ST. 8-17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas J. Hanlon

(a) RESIDENCE NO. 1808 N. Bond ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine

6 DATE OF BIRTH (month, day, and year): July 6 1876

7 AGE: Years 53 | Months 7 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mail Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): U.S.P.O.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Thos. Hanlon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Lennon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine Hanlon

(Address) 1808 Bond St

15 Filed FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb-25-30

17 I HEREBY CERTIFY, That I attended deceased from Feb-16- 1930, to Feb 25 1930, that I last saw him alive on Feb 24 1930 and that death occurred, on the date stated above, at 3-4 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Oedema Lungs (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. Jull Hall, M. D.

Feb 26 1930 (Address) 1631 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem. DATE OF BURIAL: Feb. 27 1930

20 UNDERTAKER: J. A. Moran ADDRESS 3000 E. Balto. St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is important. See instructions on back of certificates.

FEB 27 1930

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54480

CERTIFICATE OF DEATH.

++ E 54480

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Aisquith St.) No. 27 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Kalb.

(a) RESIDENCE NO. 419 E. Lehigh ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary W. Kalb.

6 DATE OF BIRTH (month, day, and year): May 26 1877

7 AGE: Years 52 Months 8 Days 29 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: American A. & Co

(b) General nature of industry, business, or establishment in which employed (or employer): Employee

(c) Name of employer: do

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Kalb.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Magdelena

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary W. Kalb (Wife)

(Address) 419 E. Lehigh St

FEB 27 1930

H. MAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1930, to Feb. 25, 1930, that I last saw h~~im~~ alive on Feb. 25, 1930, and that death occurred, on the date stated above, at 3 45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus end of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Feb. 25, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V. Mefuna, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Feb. 28th 1930

20 UNDERTAKER: Lilly & Zeibel Inc. ADDRESS: 403 S. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

233297

Under E 54481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 36-004

E 54481

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonard Newsome

(a) RESIDENCE NO. 825 Ashland Ave. WARD 9 C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abbillar Newsome

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): North Carolina

PARENTS

10 NAME OF FATHER: Washington Newsom

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 FEB 27 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-26-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to Jan 26, 1930, that I last saw him alive on Jan 26, 1930 and that death occurred, on the date stated above, at 1:35 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the seminal tract

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary tuberculosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Jan 17, 1930

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. C. Jones, M. D.

. 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cofield N. C	Feb 28 1930
UNDERTAKER: Edward Bryan	ADDRESS 1631 orleans st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54482

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 54482

CERTIFICATE OF DEATH

REGISTERED NO. 135

1—PLACE OF DEATH So. Balto Gen Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 243 Light St. ST. 24-33 WARD)

2—FULL NAME Richard Allen

(a) RESIDENCE NO. Sidmore AA Co. Md ST., Box 57 RFD WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Allen

6 DATE OF BIRTH (month, day, and year) May 10 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
60	61	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer) Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) H. A. Co Md

PARENTS

10 NAME OF FATHER Henry Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) H. A. Co. Md

12 MAIDEN NAME OF MOTHER Jane Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) H. A. Co Md

14 Informant Acton Allen (Address) Sidmore Md

15 FEB 27 1930 19 C. HAMPSON JONES, Registrar BRS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26/30

17 I HEREBY CERTIFY, That I attended deceased from 1/22, 1930, to 2/26, 1930, that I last saw h/ alive on 2/26, 1930 and that death occurred, on the date stated above, at 6 50 P m.

The CAUSE OF DEATH* was as follows: Cardiac decompensation with Edema of Lungs

(duration) yrs. 1 mos. 2 da.

CONTRIBUTORY (Secondary) Senile Hypostasis of Prostate (duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) S. J. Polenick, M. D.

, 19 (Address) 3710 Woodbine Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sidmore Md — DATE OF BURIAL Mar. 3 1930

20 UNDERTAKER Charles C. Hofa Jr. — ADDRESS Annapolis

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54483

E 54483

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4109 Massachusetts Ave (Ward) 20-11

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Law

(Residence in Baltimore: No. 4109 Massachusetts Ave St.; 4 yrs., 7 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Mar. 25, 1860. (Month) (Day) (Year)

7-AGE, 69 yrs. 11 mos. 0 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Expressman
(b) General nature of industry, business, or establishment in which employed (or employer): Hauling

9-BIRTHPLACE, (State or Country) County Antrim - Ireland

PARENTS.

10-NAME OF FATHER, Robert Law

11-BIRTHPLACE OF FATHER (State or Country). Co. Antrim - Ireland

12-MAIDEN NAME OF MOTHER Jane McMoyle

13-BIRTHPLACE OF MOTHER (State or Country). Co. Antrim - Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hugh E. Law

(Address) 2243 Ainsworth St.

15- C. HAMPSON JONES, M. D.

Filed Feb 27 1930 Registrar.

FEB 27 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Feb. 25, 1930. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 17 1930, to Feb. 25 1930, that I saw him alive on Feb. 24 1930, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 10 yrs. mos. ds.

(Signed) J. M. Engman M. D.

Feb. 25, 1930. (Address) 1425 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Greenmount

DATE OF BURIAL. Feb. 28, 1930

20-UNDERTAKER Martin Fahey & Sons

ADDRESS 1827 W. North Ave

a. Entries must be made in ink. b. Use only standard abbreviations. c. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

E 54484 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54484

CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1241 Haubert St. 24-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna A. Freichman.

(a) RESIDENCE No. 1241 Haubert St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ---- mos. --- ds. How long in U. S., if of foreign birth? 40 yrs. ---- mos. --- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Leonhard Freichman.

6 DATE OF BIRTH (month, day, and year): March 13, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	60	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. 031

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Klewer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Leonhardt Freichman. (husband)

(Address) 1241 Haubert St.

15 Filed FEB 27 1930 19 C. HA[illegible] JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): February 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 22nd, 1930, to February 25th, 1930,

that I last saw her alive on February 25th, 1930,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Adrithegia.

(duration) 10 yrs. mos. da.

CONTRIBUTORY (Secondary): Uroemia.

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto W. Heinhardt, M. D.

2/28 1930 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: Feb 28 1930

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light

N. B.—WRITE PLAINLY. WHEN ABBREVIATIONS are used they must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Bks.

E 54485

HEALTH DEPARTMENT—CITY OF BALTIMORE

74 V 001 E 54485

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Chadford Apts ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Chipman

(a) RESIDENCE NO. Chadford Apts ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 4 mos. 7 ds. How long in U. S., if foreign birth? 70 yrs. 4 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 18 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Chipman

11 BIRTHPLACE OF FATHER (city or town) Bondsville

(State or country) Mass.

12 MAIDEN NAME OF MOTHER Jane A. White

13 BIRTHPLACE OF MOTHER (city or town) Phila.

(State or country) Penna.

14 Informant Mrs. C. Benson, Duckyne Ridge

(Address) Chadford Apts.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25-30, 1930, to Feb. 25, 1930, that I last saw h[illegible] alive on Feb. 25 1930 and that death occurred, on the date stated above, at 10 25 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. 3 hours

CONTRIBUTORY (Secondary) Senile Arterio-Sclerosis

(duration) 10 + yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No - at bedside

What test confirmed diagnosis? Clinical symptoms

(Signed) A. F. Robinson, M. D.

2/26 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL Feb 27 1930.

20 UNDERTAKER Stewart & Co. — ADDRESS Balto.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

B 27 1930

Spec.—2-29-30—L. F. S.—500 Blks.

E 54486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 54486

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 22-23 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lloyd Baylor

(a) RESIDENCE NO. 20 E. Churchill st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Males	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	19	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Cash Baylor

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary (Unknown)

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

4394

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1930 to Feb. 22, 1930.

that I last saw him alive on Feb. 22, 1930

and that death occurred, on the date stated above, at 6.25 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Clinical

(Signed) M. D.

2-22-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL FEB 27 1930

20 UNDERTAKER Commissioner Health

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓

E 54487 — REGISTERED NO. E 54487

1—PLACE OF DEATH Baltimore City Hospitals (F.B. 19-26)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mahala (Hilda) Hall

(a) RESIDENCE NO. 221 Parrish st. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓ 21	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) .....

15 Filed FEB 27 1930 C. HARRISON JONES Registrar

1292

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 19 29, to Feb. 23, 19 30, that I last saw her alive on Feb. 23, 19 30 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

2-24, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19 .....

20 UNDERTAKER H.B. Commissioner Health

ADDRESS FEB 27 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

15/

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54488

E 54488

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 22-3 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Luther Love

(a) RESIDENCE NO. 105 W. Hughes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	28 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer): 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER William Love

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant (Address) Records of Balto. City Hospitals

15 Filed FEB 27 1930 Per

C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-21-30

17 I HEREBY CERTIFY, That I attended deceased from 12-19-29, 19..., to 2-21-30, 19...,

that I last saw him alive on 2-21-30, 19...,

and that death occurred, on the date stated above, at 12:50 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic Acute

(duration) 4? yrs. ... mos ... da.

CONTRIBUTORY (Secondary) Myocarditis, chronic & acute

(duration) over 2 yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Lab. N.P.V.

(Signed) Warren W. McLean, M. D.

2-22 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Potters Field

20 UNDERTAKER: Commissioner Health

DATE OF BURIAL 2/28/30

ADDRESS FEB 27 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—2-16-29—L. F. S.—100 Bks.

E 54489

E 54489 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 724 W. North Ave. 6 13-20 WARD)

2—FULL NAME Elizabeth Richers

(a) RESIDENCE NO. 724 W. North Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry N. Richers

6 DATE OF BIRTH (month, day and year) Nov. 19, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Gotto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Schier

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Wagnerin

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany.

14 Informant Carson Schuyler

(Address) 724 W. North Ave.

15 FILED FEB 27 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 20, 1930, to Feb. 25, 1930,

that I last saw h[illegible] alive on Feb 25 - 1930

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion Old age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Thos. C. Blake, M. D.

, 19 (Address) 719 Med Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Feb 28 1930

20 UNDERTAKER Fred A. Crause & Son

ADDRESS 703 S. Howard St.

IMPORTANT: Please write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54490

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54490

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3105 Fait Ave. ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME HENRY HILGEMAN Sr.

(a) RESIDENCE NO. 3105 Fait Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Hilgeman

6 DATE OF BIRTH (month, day, and year) Jan. 3. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	70	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Millwright

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1 year

(c) Name of employer Otto Duker Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Hilgeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Niehaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Anna M. Rubeling (Daughter)

(Address) 3105 Fait Ave.

15 Filed FEB 27 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25.30

17 I HEREBY CERTIFY, That I attended deceased from Nov - 20 - 1928 to Feb 25/30.

that I last saw h— alive on Feb 25 1930

and that death occurred, on the date stated above, at 3.45 p. m.

The CAUSE OF DEATH* was as follows:

Malignant Dis - Prostatic Gland -

(duration) 1 yrs. 4 mos. - ds.

CONTRIBUTORY (Secondary) General Debility

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of March 1929

Was there an autopsy? not -

What test confirmed diagnosis? ✓

(Signed) Henry C Brune M. D.

19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	Feb. 28. 1930
UNDERTAKER Henry Sander & Sons - Inc.	ADDRESS Baltimore St & Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54491

CERTIFICATE OF DEATH

90 E 54491

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1734 E. North Ave. ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CHARLES SCHEUFLER

(a) RESIDENCE NO. 1734 E. North Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna M. Scheufler

6 DATE OF BIRTH (month, day, and year) June 9. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sweater Mfg.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John G. Scheufler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Helena Rose

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss Mathilda Scheufler
(Address) 1734 E. North Ave.

15 C. HAMPSON JONES, M. D.
Registrar

FEB 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26, 1930

17 I HEREBY CERTIFY that I attended deceased from Jan 15, 1930, to Feb 26, 1930

that I last saw him alive on Feb 24, 1930

and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Ordered (duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted — —
If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What tests confirmed diagnosis? Physical

(Signed) W. C. Bladd, M. D.

(Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: Mar. 1. 1930

20 UNDERTAKER: Henry Sander & Sons. Inc. — ADDRESS: Baltimore St. & Broadway.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation very important. See instructions on back of certificates.

Cor.—10-10-23—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54492

CERTIFICATE OF DEATH

74-001

74 E 54492

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2606 Smith St. 25 72 (Ward)

2-FULL NAME Charles A Stauffer

(a) RESIDENCE NO. 2606 Smith St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)
1840

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	89			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Abraham Stauffer

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER
Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Warren Stauffer
(Address) 2606 Smith Ave

Filed ....., 19..... Registrar

827 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas H Brooke M. D.

2/27. 1930 (Address) 3601 3 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St James Cem Kenwood Co md — DATE OF BURIAL Feb 28 1930

20 UNDERTAKER J as Jacobs & Son — ADDRESS 2173 Pa...

CAUTION.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 2-29-24 1. F. S. 500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54493

E 54493

CERTIFICATE OF DEATH

49

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 W. Lanvale ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Cacy Crane

(a) RESIDENCE NO. 237 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily Levering Crane

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	-	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent County Maryland

PARENTS

10 NAME OF FATHER William Bowers Crane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent County Maryland

12 MAIDEN NAME OF MOTHER Henrietta Osborne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent County Maryland

14 Informant Mr. William B. Crane (Address) 237 W. Lanvale St.

15 Date received FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Feby. 26, 1930, that I last saw him alive on Feby 26, 1930, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinomatous leucher in a with Carcinomatous (metastasis) multiple carcinomatous (metastasis) in all bones and throughout glandular system (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of prostate (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tumor masses, Symptoms,

(Signed) Edward S Johnson, M. D.

, 19 (Address) 1212 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Feb. 28 19 30

20 UNDERTAKER Joseph S Cook

ADDRESS 1003 W. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

(Alma R. Frey.) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54494

E 54494

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2905 Mt. Holly ST. 15-65 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alma Richardson Frey

(a) RESIDENCE NO. 2905 Mt. Holly ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter R. Frey

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Indianapolis

PARENTS

10 NAME OF FATHER Edward J. Richardson

11 BIRTHPLACE OF FATHER (city or town) Schenectady (State or country) New York

12 MAIDEN NAME OF MOTHER Isabelle Stout

13 BIRTHPLACE OF MOTHER (city or town) Cincinnati (State or country) Ohio

14 Informant Mrs. Isabelle Richardson

(Address) 2905 Mt. Holly St.

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

B 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 20 1930 to February 26 1930, that I last saw h[illegible] alive on February 25, 1930, and that death occurred, on the date stated above, at About 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis Chronic (a)
Valvular Disease Chronic
Cardiac Mitral Valve (b)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) James G. Marston, M. D.

Feb. 27, 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwood Cemetery Washington, D. C.

DATE OF BURIAL March 1st 1930

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54495

CERTIFICATE OF DEATH

31 E 54495

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1474 Reynolds ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M. Morgan

(a) RESIDENCE NO. 1474 Reynolds ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced WIFE of (or) HUSBAND of

6 DATE OF BIRTH (month, day, and year) November 12, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	47.	3	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pres. operator 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Sun Decorating Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Michael J Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anna A Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mary J. Sharp (Sister)

(Address): 1474 Reynolds St

15 Filed FEB 27 1930, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 25, 30

17 I HEREBY CERTIFY, That I attended deceased from January 23, 19 30, to January 25, 19 30

that I last saw him alive on January 25, 19 30

and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pneumonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. A. Stevens, M. D.

2/25, 19 30 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Mar. 1, 19 30

UNDERTAKER: Margaret E. Filbert

ADDRESS: 1411 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54496

CERTIFICATE OF DEATH

74-E 54496

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 W. Madison ST. 11-24 WARD)

2—FULL NAME Jacob Smith Orrick

(a) RESIDENCE NO. 205 W. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 2 dys. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Nannie Hilton

6 DATE OF BIRTH (month, day, and year): March 27 1859

7 AGE — Years: 70 | Months: 10 | Days: 29 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John C. Orrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Rev. L. H. Orrick

(Address) 204 E. Chase St.

15 Filed FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 24 1930, to Feby 26 1930, that I last saw h[illegible] alive on Feby 26 1930, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

with left hemiplegia

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary): arteriosclerosis (duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no, Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical

(Signed) Chas. J. Keller, M. D.

2/27, 1930 (Address) 222 W. Monument St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemy.

DATE OF BURIAL: Feb 28 1930

20 UNDERTAKER: John O. Mitchell & Sons

ADDRESS 1900 Eutaw Pl.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 54497

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54497

CERTIFICATE OF DEATH.

REGISTERED NO. 137

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver Sts. 8-17 WARD)

2-FULL NAME Laura V. Hofstetter

(a) RESIDENCE NO. 1535 E. North Avenue ST. WARD

(Usual place of abode) (If non-resident give city or towo nod State)

Length of residence in city or town where death occurred 19 yrs. V mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Hofstetter Dr

6 DATE OF BIRTH (month, day, and year): Sept 13 1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
19	V	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Elizabeth R. Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: William H. Hofstetter

(Address) 1535 E. North ave

15 Filed FEB 27 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2-26 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-24, 1930, to 2-26, 1930, that I last saw h[er] alive on 2-26-30, 19, and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Emphysema Gall Bladder

(duration) yrs. about 1 year

CONTRIBUTORY (Secondary) Acute Nephritis & Bronchopneumonia

(duration) yrs. mos. 1 day

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 2-25-30

Was there an autopsy? no

What test confirmed diagnosis? Question

(Signed) W. H. Hofstetter, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: March 1 1930

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North Ave

C. HAMPSON JONES, M. D.

8—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE MUST BE FILLED OUT EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54498

101-001

E 54498

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 500 Rose Hill Terrace 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pauline Pecare Meyer

(a) RESIDENCE NO. 500 Rose Hill Terrace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barthold Meyer

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1857,

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	72	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York, (State or country) N. Y.

PARENTS

10 NAME OF FATHER Jacob Pecare

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Bertha Bernstein.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Richard B. Meyer

(Address) 2408 Callow Ave.

15 FEB 27 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26/30

17 I HEREBY CERTIFY, That I attended deceased from 2/16/30, 19..., to 2/26/30, 19..., that I last saw h... alive on 2/26/30, 19... and that death occurred, on the date stated above, at 11-05 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Signs

(Signed) C Hotzenwell, M. D.

2/27/30 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Feb 28 1930
20 UNDERTAKER	ADDRESS
Edwin G. Black	1421 W North ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

B 2 7 1930

Spec.—1-10-21—M&T—1500 Bks.

E 54499 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54499

CERTIFICATE OF DEATH.

100-801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1712 Lemmon ST. 19-28 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A Lease

(a) RESIDENCE NO. 1712 Lemmon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year): Sept 2, 1929

7 AGE: Years / Months 5 / Days 24 / If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: David Lease

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredk Md

12 MAIDEN NAME OF MOTHER: Anna Reinewald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs D Lease

(Address) 1712 Lemmon St

15 Filed FEB 27 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feby 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 6, 1930, to Feby 26, 1930, that I last saw her alive on Feby 25, 1930, and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) ✓ yrs. mos. 20 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill, M. D.

2/26 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 2 1930

UNDERTAKER: Joseph A Foley

ADDRESS: Fulton & Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 27 1930

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54500

CERTIFICATE OF DEATH.

× 49 E 54500

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 25-27 (WARD)

2-FULL NAME Mr. George Stewart

(a) RESIDENCE No. Maiden Choice Road Catonsville Md (ST., WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth

6 DATE OF BIRTH (month, day, and year) Sept 3 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Wm Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Rafferty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Elizabeth Stewart

(Address) Maiden Choice Road

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-13 1930 to 2-26 1930

that I last saw h[redacted] alive on 2-26 1930

and that death occurred, on the date stated above, at 11-20a m.

The CAUSE OF DEATH* was as follows:

carcinoma of pancreas

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-26-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] Cemetery

DATE OF BURIAL [redacted] 1930

20 UNDERTAKER [redacted] Fuller

ADDRESS [redacted] Fayette

B 27 1930

FILL.—WRITE PLAINLY, WITH INDELIBLE INK. THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 54501

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 54501

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 27-53

CITY OF BALTIMORE: (No. 5712 Roland Avenue ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Rita Hartmaier

(a) RESIDENCE NO. 5712 Roland Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) ---------

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
✓	78	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard I. Hartmaier

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara G. ---

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Records of Visitation
(Address) Convent - 5712 Roland Ave

15 Filed FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 1928 19.., to Feb 27, 1930, that I last saw h W alive on Feb 26, 1930 and that death occurred, on the date stated above, at 7:10 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. + mos. da.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles Bonvan M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	2/28 19 30

20 UNDERTAKER Henry U. Mears & Son ADDRESS 605 N. Calvert

NOTE FLEMISH, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54502

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 51502

CERTIFICATE OF DEATH

1—PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Frank

(a) RESIDENCE NO. 727 S. Ann St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	48	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Second Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Yankee Arrow

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Christian Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Barbara Raymer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

15 Filed FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 25, 1930

17

I HEREBY CERTIFY, That I attended deceased from December 9, 1929, to February 25, 1930, that I last saw him alive on February 25, 1930 and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of neck

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to lungs, liver & retro peritoneal lymph nodes (duration) yrs. unknown ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 12-13-29

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & autopsy findings

(Signed) Ralph E Porter, M. D.

2/27 1930 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden — DATE OF BURIAL Feb. 28, 1930

20 UNDERTAKER E. Leary Stiffler, Inc. — ADDRESS 125 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54503

CERTIFICATE OF DEATH.

17 V E 54503

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital S. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Lawrence Dashield Enniss

(a) RESIDENCE NO. 1721 Edmondson Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 74 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): February ? 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	74	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: Retired

9 BIRTHPLACE (city or town): Salisbury

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Rufus McKendre Enniss

11 BIRTHPLACE OF FATHER (city or town): Salisbury

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha Jones

13 BIRTHPLACE OF MOTHER (city or town): Salisbury

(State or country): Maryland

14 Informant: Miss. Anna M. Enniss (niece)

(Address) 626-N-Fulton Ave.

15 Filed FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

Rec'd

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Multiple Fracture

(Duration) yrs. Instant mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Feb 27/30 (Signed) C. C. Wade M. D.

(Coroner)

19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1721 Edmondson Ave.

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: Feb-28-30

20 UNDERTAKER: Stewart & Mowen Company — ADDRESS: 108-W-North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1 30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54504 E 54504

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Brandt

(a) RESIDENCE NO. 1433 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Nov 16 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	73	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record (Address)

15 Filed FEB 27 1930 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26-30

17 I HEREBY CERTIFY, That I attended deceased from 2-20, 1929, to 2-25, 1930, that I last saw him alive on 2-25, 1930, and that death occurred, on the date stated above, at 9 PM.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Myocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L.L. Lumpkin, M. D.

2-26 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetary

DATE OF BURIAL 2/28/1930

UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Dr Harry W. Gaddess 321 E 25th St
Mun V0563

E 54505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-09/734505

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 E. 31st ST., 9-46 WARD)

2-FULL NAME Kate R. Aull

(a) RESIDENCE NO. 604 E. 31st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis J. Aull

6 DATE OF BIRTH (month, day, and year) 2/6/56

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine DeBaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frank C. Freeland

(Address) 604 E. 31st st

15 Filed FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27/30

17 I HEREBY CERTIFY, That I attended deceased from 2/27/29, 19..., to 2/27/30, 19...,

that I last saw h[illegible] alive on 2/26/30, 19...,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Gaddess, M. D.

2/27/30 (Address) 321 E 25—

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 3/1/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—1-30—M. & T.—250 Blks.

Zimmerman and 2858 Hartford Rd ✓ Univ 3387

E 54506 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 54506

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 Lamont Ave ST.) 9-18 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura C. Elliott

(a) RESIDENCE NO. 1712 Lamont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles R. Elliott

6 DATE OF BIRTH (month, day, and year) June 18th 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
81	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Chas. R. Elliott

(Address) 1712 Lamont Ave

15 Filed FEB 27 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27-30

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to Feb 27, 1930, that I last saw her alive on Feb 26, 1930, and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis & myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cancer Uterus

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo L Zimmerman M. D.

2/27, 1930 (Address) 2858 Hartford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 3/1/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St. Paul St

C. HAMPSON JONES, M. D.

Health Commissioner, will be furnished. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—300 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54507

100-08 E 54507

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 824 S. Bond St. ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John R. Wojciekowski

(a) RESIDENCE NO. 824 S. Bond St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 24 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Nil

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John F. Wojciekowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ida Dmytrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant John F. Wojciekowski
(Address) 824 S. Bond St.

15 Filed FEB 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25. 1930 to Feb 27. 1930

that I last saw him alive on " 26 1930

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 2 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. Hampson Jones, M. D.

2/27/30 (Address) 408 S Pat Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means, and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary cem	Feb 28 1930
20 UNDERTAKER	ADDRESS
John M Wooden & Son	Chester

Information required by law; AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54508 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54508

CERTIFICATE OF DEATH

REGISTERED NO. 51

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1441 Reynolds ST. (OR WARD) 24-35

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Jackowski

(a) RESIDENCE NO. 1441 Reynolds ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of John Jackowski

6 DATE OF BIRTH (month, day, and year) August 27-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	64	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Private

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Francis Trawinska (Address) 1441 Reynolds St

15 C. HAMPSON JONES, M. D. Registrar

FEB 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27. 30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to Feb. 27, 1930, that I last saw h[illegible] alive on Feb. 27, 1930 and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? Yes What test confirmed diagnosis? Urinalysis & Blood exp.

(Signed) Thos F. A. Straus, M. D.

2/27, 1930 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. Balto. DATE OF BURIAL March 1 1930

20 UNDERTAKER John W. Weber & Son ADDRESS 2 Chester

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should

Spec.—1-10-21—MAT—1500 Blks.

E 54509

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 31508

CERTIFICATE OF DEATH

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 932 N Patterson Pk (St.) 7+12 (Ward) 6+60

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Haynie

(a) RESIDENCE NO. 932 N Patt Pk St.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Feb. 25, 1930

7 AGE: ✓ Years | Months | Days | If LESS than 1 day 12 hrs or ... min. 13 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓ ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): 932 N Patt Pk

PARENTS

10 NAME OF FATHER: Thomas H Haynie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Northumberland, Va

12 MAIDEN NAME OF MOTHER: Emma H McMann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Thomas H Haynie

(Address): [illegible]

FEB 27 1930

[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, 19 ... to Feb 26, 1930,

that I last saw her alive on Feb 25, 1930, 19 ...,

and that death occurred, on the date stated above, at 7 00 A m.

The CAUSE OF DEATH* was as follows:

Premature birth.
7 months.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Insufficient vitality

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Joseph Pokorny M. D.

, 19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carnegie Embryological Lab.

DATE OF BURIAL 19

20 UNDERTAKER: Wolfe & Madison Sts.

ADDRESS

Spec—12-23-21—E.B.R.S.—400 Blks.

E 54510

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 54510

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2422 Calverton Heights Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marcline V Hopkins

(a) Residence No. 2422 Calverton Heights Ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jear Hopkins

6-DATE OF BIRTH (month, day and year) Aug 5 1854

7-AGE 75 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Maryland.

PARENTS.

10-NAME OF FATHER John H. Hoopman

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Louisa Bailey

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Horace H Northington

(Address) 2422 Calverton Heights Ave

15- Filed ..... C. H. JONES, M. D. Registrar.

FEB 28 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 2-26-1930

17- I HEREBY CERTIFY, That I attended deceased from Feb. 4 1930 to Feb. 26 1930

that I last saw h[illegible] alive on Feb 26 1930

and that death occurred, on the date stated above, at 7 5½ P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis and Chronic endocarditis

(Duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism -

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? /

(Signed) Robert L. Whitehead M. D

2/27 1930 (Address) 111 W Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Harmony Cem. Harford Co. DATE OF BURIAL, 3-28 1930

20-UNDERTAKER. J. G. Pennington & Son ADDRESS Havre de Grace Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54511

CERTIFICATE OF DEATH.

90 E 54511

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 2313 W. North ave ST.) 15-68 (WARD)

2-FULL NAME Lewis Freedman

(a) RESIDENCE NO. 2313 W. North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Freedman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
✓	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Freedman

(Address) 2313 W North ave

15 Filed FEB 28 1930 Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/27/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Feb 27, 1930, that I last saw h[illegible] alive on Feb 27, 1930, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Lew Billups, M. D.

19 (Address) 2224 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mount Rd — DATE OF BURIAL 2/28 1930

20 UNDERTAKER Jack Lewis 1439 Eastern ave — ADDRESS

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/ E 54512

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 17-N Ward)

2-FULL NAME Juanita Norris

(a) RESIDENCE NO. 822 Bradley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Norris

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	23	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Reed

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth McCoy

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Daniel Norris
(Address) 822 Bradley St

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1930

17 I HEREBY ~~CERTIFY~~, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul TB-

(duration) 2 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Feb 26 30

What tests confirmed diagnosis? By Autopsy

(Signed) M. Gladys, M. D.

, 19 (Address) 172 B Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 2/28 1930

20 UNDERTAKER John H. Deadrick

ADDRESS 202 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEB 28 1930

Spec.—1-10-21—M&T—1500 Bks.

E 54513

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54513

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1032 N. Calvert St. (ST.) (WARD) 11-15

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite J. Davis

(a) RESIDENCE NO. 1032 N. Calvert St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William T, Davis

6 DATE OF BIRTH (month, day, and year): July 6th. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	74	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 0 0 D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS

10 NAME OF FATHER: James Schadrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wales

12 MAIDEN NAME OF MOTHER: Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wales

14 Informant: Lala J. Davis

(Address): 1032 N. Calvert St.

15 FEB 28 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 26th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19 . 1930 . to Feb. 26 . 1930 .

that I last saw her alive on Feb. 26 . 1930 .

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Stanley McAleer M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery.

DATE OF BURIAL: Mar. 1st 1930

UNDERTAKER: Chas. F. Waustlow

ADDRESS: 1004 Royal ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54514

CERTIFICATE OF DEATH

105 V

E 54514

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 315 N. Parrish St., 19-27 Ward)

2-FULL NAME John H. Wilson

(a) RESIDENCE NO. 315 N Parrish St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 2nd 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	49	4	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab - Odd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Jas. Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Frances Groos

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Susie Ward
(Address) 7218 Bruce St

15 Filed [illegible] Registrar

FEB 28 1930

Par [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asthma - Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brown M. D.

2/26. 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	3/1 1930
20 UNDERTAKER	ADDRESS
Mrs Katie R. Williams	322 N Schroeder

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54515

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54515

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. 11-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. James G. Gittinger

(a) RESIDENCE NO. 613 St. Paul St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 10 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) ~~WIFE~~ of Mrs. James C. Gittinger

6 DATE OF BIRTH (month, day, and year) March 18, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
✓	79	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Mr. James Gittinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Alexander Warner

(Address) 613 St. Paul St.

Filed FEB 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1930, to Feb 27, 1930, that I last saw h~~im~~ alive on Feb 27, 1930 and that death occurred, on the date stated above, at 8 40 P.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At 613 St. Paul St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) H. T. Offutt Jr., M. D.

Feb 27, 1930 (Address) 1 W. Mt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount

DATE OF BURIAL Mar 1 1930

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh & Eutaw

IMPORTANT: This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E. 54516

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54516

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. 27-44

CITY OF BALTIMORE: (No. ..... ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Kuhn

(a) RESIDENCE NO. 5300 Carter Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Rose Kuhn

6 DATE OF BIRTH (month, day, and year): Jan. 30-1877

7 AGE: Years 53 | Months | Days 27 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer: Katz & Son

9 BIRTHPLACE (city or town) (State or country): Servia

PARENTS

10 NAME OF FATHER: Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Servia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Servia

14 Informant: Alfred Kuhn

(Address): 5300 Carter

15 Filed ..... 19 ..... Registrar

FEB 28 1930

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 2/27/30

17

I HEREBY CERTIFY, That I attended deceased from 2/27, 19 30, to 2/27, 19 30, that I last saw h[illegible] alive on 2/27/30, 19 ..... and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary): Ruptured Gastric Ulcer & Peritonitis (duration) ..... yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 2/27/30

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) David Gerne, M. D.

2/27, 19 30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem.

DATE OF BURIAL: March 1, 19 30

20 UNDERTAKER: Leonard J. Ruck

ADDRESS: 6405 Belair Road

Spec.—1-12-23—M&T—500 Blks.

54517

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54517

1-PLACE OF DEATH Hebrew Home for the Aged on Greenspring Ave

CITY OF BALTIMORE: (No. Belvedere & Greenspring Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Rody

(a) RESIDENCE NO. Belvedere & Greenspring Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Uncertain

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
67				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address)

15 Filed FEB 28 1930 . 19 C. HARRY JONES, M. D. Registrar

SIGMUND FEINBLATT SUPERINTENDENT CHARITY & CORRECTION

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb-27-1930

17 I HEREBY CERTIFY, That I attended deceased from July — . 1929 . to Feb. 27 — . 1930 .

that I last saw h[illegible] alive on Feb - 27 — . 1930

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

about 5-6 yrs

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. One da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical [illegible]

(Signed) Hermann Feindel, M. D.

2/28 1930 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash. Road — DATE OF BURIAL 2-28-1930

20 UNDERTAKER Jack Lewis, 1439 E Balto — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-20-28—L. P. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 54518

E 54518 REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6601 Hamptsett St. 27-43 WARD)

2—FULL NAME Helen Fritsch

(a) RESIDENCE NO. 6601 Hamptsett ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ambrose Fritsch

6 DATE OF BIRTH (month, day, and year) March 7/1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 237

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Fachterman

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Rosina Stern

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Ambrose Fritsch
(Address) 6601 Hamptsett

15 Filed FEB 28 1930 C. HANFORD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 25, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to Feb 25, 1930, that I last saw h.er alive on Feb 25, 1930, and that death occurred, on the date stated above, at 7.15 p m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis heart disease

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) [illegible] M. D.

Feb 27 19 (Address) Maplewood Relay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr. G. Rd Cem - Mar 1 - 30	
20 UNDERTAKER	ADDRESS
for J. Stemmon & Son	156 Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54519 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 54519

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 9-18 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin Malloy

(a) RESIDENCE NO. ? 1614- Holbrook St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown 12-1-87

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	57	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of (Address) Baltimore City Hospitals

15 Filed FEB 28 1930 H. HANSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27-30

17 I HEREBY CERTIFY, That I attended deceased from 1-22-26, 19..... to 2-27-30, 19.....

that I last saw him alive on 2-27-30, 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. Davis M. D.

2-27, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Hanford Rd DATE OF BURIAL 3/1/30 19

20 UNDERTAKER George J. Path ADDRESS 1735 Hanford

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54520

74-001

E 54520

CERTIFICATE OF DEATH

REGISTERED NO. 8-12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207. N. Montford ave ST. WARD)

2—FULL NAME James. F Watsie

(a) RESIDENCE NO. 1207. N. Montford ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Watsie.

6 DATE OF BIRTH (month, day, and year) August 26/1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush maker

(b) General nature of industry, business, or establishment in which employed (or employer) Pittsburg Glass Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Anton Watsie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Francis Novak.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Gertrude. Watsie (Address) 1207. N. Montford ave.

15 Filed FEB 28 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26. 30

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 1930 to Feb 26 1930,

that I last saw h[illegible] alive on Feb 26 1930

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rosanelli M. D.

Feb. 28. 1930 (Address) 801 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemty.	March 1. 1930

20 UNDERTAKER George. J. Ruth ADDRESS 1735. Harford ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54521 179 ✓ E 54521

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 19-29 Ward)

2-FULL NAME Vlada Milich

(a) RESIDENCE NO. 1309 W Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years ✓ 62 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Ordinary
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Serbia

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Serbia

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Serbia

14 Informant: Michael Chronkovich
(Address) 351 S Eddison Ave

15 Filed ..... 19..... Registrar

FEB 10 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

ACC Burns.

F. Franks

Feb 27 30

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C C Glades M. D.

19 (Address) 1730 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL: Mch 1 1930

20 UNDERTAKER: A. Jones | ADDRESS: W Lidum

REGISTER—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Maher

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph Hospital REGISTERED NO. 101 E 54522

CITY OF BALTIMORE, No. Edmondson Ave St., (WARD) 56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Maher

(a) RESIDENCE NO. 1203 Ensor St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of "

6 DATE OF BIRTH (month, day, and year) Dec 28, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Richard L. Maher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER M. Elizabeth Ragan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mother Mrs. Elizabeth Maher (Address) 1203 Ensor St.

15 FILED FEB 23 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-7-30, 19 to 2-28-30, 19, that I last saw h alive on 2-28-30, 19, and that death occurred, on the date stated above, at 10, 9 m.

The CAUSE OF DEATH* was as follows:

Lung Abscess (bronchopneumonia 12-26-29) (duration) yrs. mos 40 ds.

CONTRIBUTORY (Secondary) Toxaemia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 2-8-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M B Hendrix, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemy DATE OF BURIAL Mar 3 1930

20 UNDERTAKER Edward W. Conklin ADDRESS 924 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54523

CERTIFICATE OF DEATH

24-33 185

E 54523

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1406 Jackson St. St., 24 Ward)

2-FULL NAME Robert K. Neugebauer.

(a) RESIDENCE NO. 1406 Jackson St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. How long in U. S., if of foreign birth 42 yrs.

NB—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dora Neugebauer.

6 DATE OF BIRTH (month, day, and year) November 9, 1851

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
✓	78	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER Carl G. Neugebauer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Ernestina Koehler.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Dora Neugebauer. (wife)
(Address) 1406 Jackson St.

15 FEB 28 1930 HAMPTON HAWES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 26, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of the brain
Occidental fall down a stairway.

(duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? February 24, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

2/27 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. — DATE OF BURIAL March 1930

20 UNDERTAKER E. Schloman & Son — ADDRESS 1039 Hanover

Spec.—1-10-21—M&T—1500 Bks.

E 54524 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54524

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvester Mason

(a) RESIDENCE NO. 562 Orchard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	27	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn N.Y.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Dollie Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Evelyn Mason

(Address) 412 New Jersey Ave N.W.

15 Washington D.C.

Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26-1930

17 I HEREBY CERTIFY, That I attended deceased from 2-18-30, 19 , to 2-26-30, 19 ,

that I last saw him alive on 2-26-30, 19 ,

and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Left Lobar Pneumonia.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation,

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? X-Ray.

(Signed) M.B. Hundley, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg Va

DATE OF BURIAL 2/28 1930

20 UNDERTAKER Samuel I. Hemsley

ADDRESS W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEB 28 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54525

CERTIFICATE OF DEATH

E 54525

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 Madison Ave ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah A. Garrison

(a) RESIDENCE NO. 1012 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joshua D. Garrison.

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Levi A. Kellum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fannie Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Frances C. Garrison

(Address) 1012 Madison ave.

15 Filed 19 Registrar

FEB 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb 26, 1930, that I last saw her alive on Feb 25, 1930 and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. McRae, M. D.

2/26, 1930 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem. Mch.	1 1930
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	416 N. Carolina St.

Information should be carefully supplied. Note should be taken of the Instructions printed on the back hereof. Every OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54526 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54526

CERTIFICATE OF DEATH. 44

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 1-3 WARD)

2-FULL NAME Casper Rys

(a) RESIDENCE NO. 2104 Cambridge ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred (yrs. 25) mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Casper Rys

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
52	51?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Sat Rys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Sophie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Record (Address)

EB 28 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-26-30

17 I HEREBY CERTIFY, That I attended deceased from 11-12, 1929, to 2-26, 1930, that I last saw him alive on 2-26, 1930, and that death occurred, on the date stated above, at 9 10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

2-26 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Mch. DATE OF BURIAL 1 1930

20 UNDERTAKER J. Wozgowski 1930 ADDRESS Fenture Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Dr Eastland. Med Arts

E 54527 HEALTH DEPARTMENT—CITY OF BALTIMORE E 3 odrw 54527

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2909 ½ North Ave St. 15-67 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carmen J. Cooper

(a) RESIDENCE NO. 2909 W North Ave St., WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Name illegible

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Cooper

6 DATE OF BIRTH (month, day, and year) May 24. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer A Stone

9 BIRTHPLACE (city or town) (State or country) Brazil S A

PARENTS

10 NAME OF FATHER Pedro De Mello

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brazil S. A.

12 MAIDEN NAME OF MOTHER Jeannette Lindrode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brazil S A

14 Informant Louis Cooper

(Address) 2909 W North Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

B 2 8 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26. 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to Feb. 26, 1930, that I last saw her alive on Feb. 25, 1930, and that death occurred, on the date stated above, at 8¼ A m.

The CAUSE OF DEATH* was as follows:

Paget's disease

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Sheldon Eastland, M. D.

19 (Address) 323 Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mustura Elm

DATE OF BURIAL 3/1 1930

20 UNDERTAKER Wm. Cook

ADDRESS 1217 St Paul St

mation should be carefully supplied. Age should be stated. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 54528

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54528

CERTIFICATE OF DEATH.

31

N.B.—WHITE PAPER, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 147 S. Ellwood Ave WARD 12)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer West

(a) RESIDENCE No. 147 S. Ellwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha E. West

6 DATE OF BIRTH (month, day, and year) Jan. 13-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
✓	42	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager 09

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Appleby Grocer Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md

PARENTS

10 NAME OF FATHER Columbus West

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret Koerber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Bertha E. West

(Address) 147 S. Ellwood ave

15 Filed FEB 28 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930, to Feb. 27, 1930, that I last saw him alive on Feb. 27, 1930 and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Haemoptysis - probably due to Pulmonary tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Gelbert, M. D.

2/28. 1930 (Address) 2739 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery

DATE OF BURIAL 3/1 1930

20 UNDERTAKER W. Cook

ADDRESS 12 1/2 S. Paca

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54529

49 E 54529

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1197 N. Ann St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna L. Prasch.

(a) RESIDENCE NO. 1197 N. Ann St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 Color or Race: white | 5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) ~~WIFE of~~: wife of Ferdinand Prasch

6 DATE OF BIRTH (month, day, and year): Aug 18, 1858

7 AGE: Years: about 71 | Months: 6 | Days: 9

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: James Garrett

11 BIRTHPLACE OF FATHER (City or town): England.

(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: John Prasch Jr.

(Address) 1197 N. Ann St.

15 [illegible] 19 [illegible] Registrar

NRA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb. 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1930 to Feb. 27, 1930

that I last saw her alive on Feb. 27 1930

and that death occurred, on the date stated above, at 8 35 P. m.

The CAUSE OF DEATH* was as follows: Cancer of the Kidney

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Margaret B. Ballard M. D.

2/27 19 (Address) 605 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer | Date of Burial: 3/3 1930

20 UNDERTAKER: William Cook | ADDRESS: 1217 St. Paul

FEB 28 1930

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Rachel Holmes)

Spec.—1-10-21—M&T—1500 Bks.

E 54530

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54530

CERTIFICATE OF DEATH.

100-80

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 936 N. Eutaw ST. 11-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Holmes (Widow)

(a) RESIDENCE NO. 936 N. Eutaw ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur Holmes

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 51 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Charleston S. C.

PARENTS

10 NAME OF FATHER: James Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Martha Young

(Address): 916 N. Carrollton Ave

15 Filed FEB 28 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1930, that I last saw h alive on Feb 26 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

Signed: J. Lee Chis, M. D.

(Address) 924 Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: N. Cemetery

DATE OF BURIAL: 2/28 1930

20 UNDERTAKER: Samuel Easton

ADDRESS: 916 Pacific

FEB 28 1930 C. HAMPSON, M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16 001 ✓

E 54531

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 943 N. Collington ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward L. Harrington

(a) RESIDENCE NO. 743 N Collington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 28/30

7 AGE: Years | Months | Days | If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John E. Harrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Louise Paddock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John E. Harrington

(Address) 743 N Collington Ave

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to Feb 28, 1930, that I last saw him alive on Feb 28, 1930, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William F. Kyle Lauer M. D.

Feb 28, 1930 (Address) 801 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Mar 1 1930

20 UNDERTAKER: Fred Roach for 1906 Edmondson

ADDRESS

FEB 28 1930

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Blks.

E 54532

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54532

CERTIFICATE OF DEATH.

REGISTERED NO. 2863

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 4408 Belview Ave ST. WARD)

2-FULL NAME Carl Ludwig Harlitz

(a) RESIDENCE No. 4408 Belview Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louisa S. Harlitz.

6 DATE OF BIRTH (month, day, and year) Mar 4/1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired piano maker

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hasleben Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Unknown

14 Informant Louisa S. Harlitz (Address) 4408 Belview Ave

15 Filed C. HAMPSON JONES, M. D. 19 Registrar

B 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to Feb 28, 1930, that I last saw h[im] alive on Feb 28, 1930, and that death occurred, on the date stated above, at 10 42 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach about 1 yr

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) about 1 yr mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Walter S. Hilbert, M. D.

3/25, 1930 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF DISPOSITION OR REMOVAL [illegible] Cemetery — DATE OF BURIAL Mar 3 1930

20 UNDERTAKER Harry H Ammon — ADDRESS 4204 Ridgewood Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54533 101-001 E 54533

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 42 E. York St. St., 22-6 Ward)

2-FULL NAME Matthew Lynn.

(a) RESIDENCE NO. 42 E. York St. St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 40 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mollie Lynn.

6 DATE OF BIRTH (month, day, and year) October 20, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
/	66	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland.
(State or country)

PARENTS

10 NAME OF FATHER William Lynn.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Elizebeth Kiera[illegible]

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland.

14 Informant John Lynn. (son)
(Address) 1407 Riverside Ave.

15 Filed 2 8 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 27, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

..... (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Steinhard M. D.

2/28 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	March 10
20 UNDERTAKER	ADDRESS
Margret E. Flynn	1422 Ingleside

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 51534 — E 51534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 325

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gladys Bonne

(a) RESIDENCE NO. 2431 Huron ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest Bonne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Gladys Shuster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 1 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 27/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Feb 27, 1930, that I last saw her alive on Feb 27, 1930 and that death occurred, on the date stated above, at 4-15 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic pancarditis

Bronchopneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. W. Bakford, M. D.

2/27, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Mar 1 1930

20 UNDERTAKER Virginia A Brooks

ADDRESS 1463 N. Carey St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 54535

REGISTERED NO.

E 54535

1-PLACE OF DEATH

City of BALTIMORE: (No. 1010 N. Carey St. Ward 16-23

2-FULL NAME John B. Kent.

(a) RESIDENCE NO. 1010 N. Carey St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Kent.

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Calvert Co.

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Harry Kent

11 BIRTHPLACE OF FATHER (City or town) Calvert Co.

(State or country)

12 MAIDEN NAME OF MOTHER Mary Chase

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.

(State or country)

14 Informant (Address) Daniel Hawkins 1020 Parish St.

15 Filed 19

Registrar

MAR 1 - 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28- 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-19-, 1930, to 2-26-, 1930, that I last saw him alive on 2-26-, 1930, and that death occurred, on the date stated above, at 2 A.m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Frank A. Saunders M. D.

2-28-1930 (Address) 1029 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

Date of Burial Mar 2 19

ADDRESS

20 UNDERTAKER Virginia A. Brooks 1423 N. Carey St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54536 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54536

CERTIFICATE OF DEATH.

REGISTERED NO. 160

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 735 S. Eonkeling ST., 26-37 WARD

2-FULL NAME Donald Joseph Schneider

(a) RESIDENCE NO. 735 S. Eonkeling ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14th 1929

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Andrew G. Schneider

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Katherine E. Stumm

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Andrew G. Schneider
(Address) 735 S. Eonkeling St

Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 28, 1930, that I last saw h alive on Feb 25, 1930, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Marasmus
Malnutrition

(duration) yrs. mos 10 da.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj O'M'Cleary, M. D.

(Address) 40 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Town Cemetery — DATE OF BURIAL March 1 1930

20 UNDERTAKER Lilly & Julian Sale — ADDRESS 403 N. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ART

Spec.—8-16-29—L. F. S.—100 Bks.

Z 3 4406
E 54537

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 54537

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edgar A. Collins.

(a) RESIDENCE NO. 3919 Fait ave ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George H. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Yingling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 1 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to Feb 27, 1930, that I last saw him alive on Feb 27, 1930, and that death occurred, on the date stated above, at 2 10 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? not confirmed.

(Signed) R. O. Y. Warren, M. D.

2/27, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Mch 1st 1930

20 UNDERTAKER: Lilly & Zeiler Inc. — ADDRESS: 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54538

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54538

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home & Infirmary 6-9 WARD)

2—FULL NAME Mrs. Thomas Cadle

(a) RESIDENCE NO. Laurel, Maryland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R.R. Co.

9 BIRTHPLACE (city or town) Savage
(State or country) Md

PARENTS

10 NAME OF FATHER James Cadle

11 BIRTHPLACE OF FATHER (city or town) Savage
(State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Leiper

13 BIRTHPLACE OF MOTHER (city or town) Savage
(State or country) Md

14 Informant Maine Cadle
(Address) Savage Md.

15 Filed 1 - 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/20, 1930, to 3/1, 1930, that I last saw h.. alive on 2/28, 1930 and that death occurred, on the date stated above, at 2:40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis, arteriosclerosis, hypertension (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No - refused

What test confirmed diagnosis? Laboratory & clinical

(Signed) M E Jones, M. D.

3/1, 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Savage Md

DATE OF BURIAL 3/3/30

B. UNDERTAKER Lloyd Kaiser

ADDRESS Laurel Md

AR 1 - 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 54539

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 S. Smallwood ST. 20-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Kempf

(a) RESIDENCE NO. 433 S. Smallwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ... ds. How long in U. S., if foreign birth? 50 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Anna E. Kempf (nee Nebel)

6 DATE OF BIRTH (month, day, and year) March 5, 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
50	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer Miller Brothers

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Kempf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Seillk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Kempf (Address) 433 S. Smallwood St.

15 Filed MAR 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feby. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from April, 1928, to Feby 27, 1930, that I last saw him alive on February 26, 1930 and that death occurred, on the date stated above, at 8. a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Valvular disease of the heart (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically ss.

(Signed) L. H. Hoffman, M. D.

2/28/1930 (Address) 8 East Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 3/1/30 19

20 UNDERTAKER Harry N. Witzke. 4101

ADDRESS Edmondson Ave.

AR 1 1930

IMPORTANT—Before signing, read carefully, so that it may be properly classified. Exact statement of OCCUPATION necessary. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54540

CERTIFICATE OF DEATH.

16-98 1 54540

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 18-29 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Velleggia

(a) RESIDENCE NO. 825 Hollins St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-25-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Enria

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary D'Angelo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mr Enria Velleggia

(Address) 825 Hollins St

15 Filed APR 1 - 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-28, 1930, to 2-28, 1930, that I last saw her alive on 2-28, 1930, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George Brenner, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 3/1 1930

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54541 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 54541

90

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE. (No.) 318 Overhill Rd (Ward) 42-49

2-FULL NAME Ida V. Roberts.

(a) RESIDENCE NO. 318 Overhill Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 65 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Samuel H. Roberts

6 DATE OF BIRTH (month, day, and year) Apr. 23, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS
10 NAME OF FATHER Samuel Barnes
11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)
12 MAIDEN NAME OF MOTHER Elizabeth Dobson
13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant M. Raymond Roberts.
(Address) 318 Overhill Rd. Md.

15 1930 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to Feb. 26, 1930, that I last saw h[illegible] alive on Feb. 26, 1930, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:
Auricular Fibrillation
Mitral Insufficiency
(duration) ..... yrs. ..... mos 2 ds.
CONTRIBUTORY (Secondary) Chronic Endocarditis
(duration) 15 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Physical signs
(Signed) M. Gibson Forlen, M. D.
2/28 1930 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Mar 1 1930

20 UNDERTAKER Wm. Tuckner & Sons — ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

R 1

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54542

CERTIFICATE OF DEATH

Facts of Death

E 54542

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bethlehem Ship Building Co. St., 24-33 Ward)

2-FULL NAME John Hirshfeld.

(a) RESIDENCE NO. New York. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	84	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boatsman.
(b) General nature of industry, business, or establishment in which employed (or employer) S/S Eurana
(c) Name of employer

9 BIRTHPLACE (city or town) Russia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Dr. G. A. C Stem.
(Address) Bethlehem Ship Building Co.

15 Filed MAR 1 1930, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 27, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Occidental fall from a mast of
s/s Eurana.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt M. D.

2/28, 1930 (Address) 1013 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

DATE OF BURIAL March 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24 E 54543

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Cumberland

(a) RESIDENCE NO. 1705 W Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Thomas

6 DATE OF BIRTH (month, day, and year) Jan 27, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	26	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Cumberland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mattie Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Annie Cumberland

(Address) 1705 W Lexington St

15 Filed MAR 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1930, to Feb 27, 1930, that I last saw h~~im~~ alive on Feb. 27, 1930 and that death occurred, on the date stated above, at 9.15 a m.

The CAUSE OF DEATH* was as follows:

Meningitis
(Meningococcic)
(duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY —
(Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) Myron G. Tull, M. D.

3/1, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 3-1-1930

UNDERTAKER Dent Easton ADDRESS 916 Pine

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54544

CERTIFICATE OF DEATH

90 ✓ E 54544

1—PLACE OF DEATH

REGISTERED NO. 13559

CITY OF BALTIMORE: (No. Cordova Apts. ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Yette Langfeld

(a) RESIDENCE NO. Cordova Apts. 2 C. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced
HUSBAND of (or) WIFE Daniel Langfeld

6 DATE OF BIRTH (month, day, and year) Feb. 25, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Reifsfelder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Beckendorfer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. A. Wertheimer
(Address) Cordova Apts.

15 Filed MAR 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1930, to Feb. 27, 1930, that I last saw h er alive on Feb. 27, 1930 and that death occurred, on the date stated above, at 2.45 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis with gradual increasing insufficiency Arteriosclerosis several (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Increasing Cardiac failure (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) Frank J. Smith, M. D.

2/28, 1930 (Address) 927 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har Sinai Cem.	3/2/1930
20 UNDERTAKER Sigurd Sondheim	ADDRESS 418 20 W. Mt. Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54545

CERTIFICATE OF DEATH.

E 54545

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1312 Harlem Ave. (ST.) 16-23 (WARD) 101

2-FULL NAME Lola May Smith.

(a) RESIDENCE NO. 1312 Harlem Ave. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 9th. 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	8	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work..... Unemployed
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS
10 NAME OF FATHER Daniel E. Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country) Columbia, Tenn.
12 MAIDEN NAME OF MOTHER Lena Jackson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington, D.C.

14 Informant Danl. Smith.
(Address) 1312 Harlem Ave.

Filed APR 1 1930 19.. RPN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24th. 19 30. to Feb. 27th. 19 30.
that I last saw h alive on Feb. 26th. 1930
and that death occurred, on the date stated above, at 1.35 m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(duration) yrs mos 3 ds.
CONTRIBUTORY (Secondary) Acct. Bronchitis
(duration) yrs mos. 6 ds.

18 Where was disease contracted (if not at place of death)? At place of death
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Physical Exam.
(Signed) Walter J. Jackson, M. D.
19 (Address) 1631 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery
DATE OF BURIAL 3/1 1930
20 UNDERTAKER Thomas G. Kelson
ADDRESS 1303 Pennsylvania Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54546 90 E 54546

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N. Spring ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. H. Thomas

(a) RESIDENCE NO. 413 N. Spring ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Thomas

6 DATE OF BIRTH (month, day, and year) [illegible] 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Clarkson

13 BIRTHPLACE OF MOTHER (city or town) [illegible] (State or country)

14 Informant Annie Thomas (Address) 413 N. Spring St.

15 Filed MAR 1 1930 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-25-30

17 I HEREBY CERTIFY, That I attended deceased from 2-23-, 1930, to 2-25-, 1930, that I last saw h[illegible] alive on 2-25-, 1930, and that death occurred, on the date stated above, at 9, 30 A. m.

The CAUSE OF DEATH* was as follows:

Valvulitis

Interval.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Longcope, M. D.

2-25-1930 (Address) 611-4 Cond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Mar 1 1930

UNDERTAKER D. Mary R. G. Elliott — ADDRESS 1225 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54547 ✓ 118-002 E 54547

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO. 13-50

CITY OF BALTIMORE: (No. ____ St. ____ WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Fulton Jones Jr

(a) RESIDENCE NO. 2539 McCulloh St ST., ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Genora Jones

6 DATE OF BIRTH (month, day, and year) April 28, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	27	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Co. Va.

PARENTS

10 NAME OF FATHER John M. Jones Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Roanoke Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Genora Jones

(Address) 2539 McCulloh

15 Filed ____ 19 ____ Registrar

C. HAMPSON JONES, M. D.

MAR 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/30

17 I HEREBY CERTIFY, That I attended deceased from 2/22/30, 19____, to 3/1/30, 19____, that I last saw h... alive on 3/1/30, 19____, and that death occurred, on the date stated above, at 2 A.M. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ____ yrs. ____ mos. 4½ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2/22/30 & 2/27/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Jones, M. D.

3/1/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester C.H. Va

DATE OF BURIAL 3/1 1930

20 UNDERTAKER Frank W. Evans & Son

ADDRESS 1400 Myrtle

IMPORTANT: Information should be carefully supplied, and should agree with that given on BIRTH CERTIFICATE. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 54548

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 V

E 54548

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH N.

CITY OF BALTIMORE: (No. 808 Carrollton Ave Ft 6-23 WARD)

2-FULL NAME Baby Boy Freeman

(a) RESIDENCE NO. 808 Carrollton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 26, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work ..... NONE

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Howard Frazier

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D.C.

12 MAIDEN NAME OF MOTHER Lillian Hubbard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant .....
(Address) .....

15 Filed MAR 1 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1930, to Feb. 28, 1930, that I last saw him alive on Feb. 28, 1930, and that death occurred, on the date stated above, at 4 55 P. m.

The CAUSE OF DEATH* was as follows:

Maternal Syphilis

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Prematurity none

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Not Date of .....

Was there an autopsy? Not Maternal Wasserman

What test confirmed diagnosis? Placental Signs A

(Signed) Placenta St. Isabel M. D.

2/28 1930 (Address) Maternity Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL MAR 1 - 1930

20 UNDERTAKER [illegible]

ADDRESS .....

B.—WRITE PLAINLY, with unfading ink. The items of this certificate should be answered with the utmost care. PHYSICIANS should be particular to see that every item is carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MAR 1 - 1930

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54549

CERTIFICATE OF DEATH

11-001 E 54549

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 143 W. West St Ward 2231)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Griffin Maker

(a) RESIDENCE NO. 143 W West St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Maker

6 DATE OF BIRTH (month, day, and year) Aug 3 1885

7 AGE 41 Years 6 Months 24 Days IF LESS than 1 day hrs. or min.

42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home 37

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) County MD

PARENTS

10 NAME OF FATHER Wm W Griffin

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Washington DC

12 MAIDEN NAME OF MOTHER Catherine Williams

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co

(State or country) Baltimore Co MD

14 Informant Wm Maker

(Address) 143 W West St

15 Filed MAR 1 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1930 19

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1929, to Feb 27, 1930, that I last saw her alive on July 27, 1929, and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) influenza c

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Pneumonia

(Signed) Chas F Edwards M. D.

19 (Address) 1504 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shary St Ct Chase Md

Date of Burial March 2 1930

20 UNDERTAKER S L Brown and Son

ADDRESS Town & County

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 54550

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument & Rutland ST. 27-56 WARD) 111

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Lewis

(a) RESIDENCE No. 3037 - Belvedere Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. - mos. - ds. How long in U. S., if of foreign birth? 17 yrs. -- mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Baker

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Poole & Hunt

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER Steven Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Mary ------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ------

14 Informant Mrs. Alice B. Lewis

(Address) 3037 Belvedere Avenue

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

MAR 1 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb 21 .1930. to Feb 28 .1930.

that I last saw him alive on Feb 28 .1930.

and that death occurred, on the date stated above, at 10:40 p m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric Ulcer

8 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 1. Bronchopneumonia 4 da 2. Uremia 12 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 21.

Was there an autopsy? yes.

What test confirmed diagnosis? Hist. Phys. exam., Operation

(Signed) C. H. Jones M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 3/3 1930

20 UNDERTAKER Henry W. Mears and Son

ADDRESS 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54551 — CERTIFICATE OF DEATH — 45 — E 54551

REGISTERED NO.

A—PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hosp. St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. John Moncure

(a) RESIDENCE NO. Lutherville Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Moncure married

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 / 49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) Md. Colleges

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER H. R. L. Moncure

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Moncure

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Louis Latane

(Address) 3311 Burleith Balto

15 Filed MAR 2 - 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21 1930 to March 1 1930, that I last saw h. alive on March 1 1930 and that death occurred, on the date stated above, at 7 35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb. 24, 1930

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George W. Yeager, M. D.

Mar. 1. 1930 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Faters Cemetery

DATE OF BURIAL March 4th 1930.

20 UNDERTAKER P. McBurney Sons

ADDRESS Towson

Information to be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54552

CERTIFICATE OF DEATH

129 ✓

REGISTERED NO. E 54552

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 Arlington Ave ST. 27-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Earle Mish

(a) RESIDENCE NO. 709 Arlington Ave ST. Govans WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	59	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Josiah Keesee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Lucy Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lynchburg Va

14 Informant Mrs Ballard R. Smith

(Address) 709 Arlington Ave, Govans

15 Filed MAR 2 - 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 - 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feby 20th, 1930, to March 1st, 1930, that I last saw her alive on March 1st, 1930 and that death occurred, on the date stated above, at 1 30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

& Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cholecystatitis & Chronic Nephritis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Jos Clift, M. D.

Mar 1. 1930 (Address) 3532 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Staunton, Virginia

DATE OF BURIAL March 2, 1930

20 UNDERTAKER E. Leroy Stiffler, Inc.

ADDRESS 125 E. North ave

Spec.—8-16-29—L. F. S.—100 Bks.

233803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54553 + 49 ✓ E 54553

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sidney Levy

(a) RESIDENCE NO. Brooklyn N York ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 09

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	11	4 6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Gussie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 2 - 1930 19 HARRY M. JONES, M. Registrar

By RMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1- 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1930, to March 1, 1930, that I last saw h.i.m. alive on March 1, 1930 and that death occurred, on the date stated above, at 940 P m.

The CAUSE OF DEATH* was as follows:

Had Brain tumor. Sulonolic Sarcoma.

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 13.II.30.

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) E.H. Compton Jr. M. D.

3/1. 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brooklyn N Y

DATE OF BURIAL 3/2 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1167 E Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54554 — CERTIFICATE OF DEATH — +10-001 — E 54554

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 9-45 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Earl R. Lindemon

(a) RESIDENCE NO. Windsor Mill Road-Woodlawn ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Non Resident yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	0	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. County

PARENTS

10 NAME OF FATHER Robt Lindemon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Lula Meadows

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Robt. Lindemon

(Address) Windsor Mill Road - Woodlawn

15 Filed MAR 2 - 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1930, to March 1, 1930, that I last saw him alive on March 1, 1930 and that death occurred, on the date stated above, at 9:25 a.m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(daration) ....yrs. 3 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Feb. 28, 1930 Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical - Post Mort.

(Signed) Nyson G. Gill, M. D.

3/1, 1930 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL Mar. 2, 1930

UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Calto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 54555

CERTIFICATE OF DEATH.

B 54555

25-72 10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3641 Hineline Road, Violetville WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Block

(a) RESIDENCE No. 3641 Hineline Road, Violetville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Block

6 DATE OF BIRTH (month, day, and year) Dec. 19, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Kolb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Charles Block

(Address) 3641 Hineline Ave., Violetville

15 Filed ..... C. H. [illegible] JONES, M. D. Registrar

MAR 2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to Feb 28, 1930, that I last saw h[illegible] alive on Feb 28, 1930 and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis Lobar pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) F. T. Kyper, M. D.

3/1, 1930 (Address) 3321 Fleetwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Mar 3 1930

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St

MAJOR should be entirely supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54556

CERTIFICATE OF DEATH

129 ✓ E 54556

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2730 Brehm's Court WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George T. Griffee

(a) RESIDENCE NO. 2730 Brehm's Court WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 4 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella L Griffee

6 DATE OF BIRTH (month, day, and year) Oct 1=1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of indastry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Geo Griffee

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna

12 MAIDEN NAME OF MOTHER Elizabeth Lyons

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not known

14 Informant Ella L Griffee
(Address) 2730 Brehm's Court

15 Filed MAR 2 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928 to Feb 28, 1930, that I last saw him alive on Feb 27, 1930 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Myocarditis, Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) E. H Donella, M. D.

, 19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 3 1930
20 UNDERTAKER Henry Lutz	ADDRESS 1203 Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54557

CERTIFICATE OF DEATH

185 VE 51357

1-PLACE OF DEATH

City of Baltimore: (No. 1924 Henneman St., 413 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Hutchins

(a) RESIDENCE NO. 1924 Henneman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19/1916

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	13	8 7	7 8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph Hutchins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Ella Morris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Joseph Hutchins
(Address) 1924 Henneman Ave

15 Filed MAR 2 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia-Accidently slipped (apple on sidewalk) Oct 12/29. Frad. left femur. Later amputation-(sarcoma? Periosteal tumor) (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 15/29

Was there an autopsy? at Hopkins

What test confirmed diagnosis?

(Signed) [signature] M. D.

2/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: March 1st 1930

20 UNDERTAKER: Milton Davis

ADDRESS: 413 N Eden St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 54558

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54558

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 623 E. 41 St. 9-46 Ward)

Registered No. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna E. Snyder

(a) Residence No. 623 E. 41 St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (write the word): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Feb 14 1853

7-AGE: 77 yrs. 14 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 68

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.

10-NAME OF FATHER: Henry Snyder

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Pa

12-MAIDEN NAME OF MOTHER: Caroline Garrod

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Pa

14- (Informant) Mrs Alford Edel

(Address) Ashendene Bgd

15- Filed MAR 2 - 1930 C. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb 28-30

17- I HEREBY CERTIFY, That I attended deceased from Jan 3 1930 to Feb 28 1930.

that I last saw h. alive on Feb 28 1930.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) 1+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. W. Bishop M. D.

Mch 1, 1930 (Address) 501 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL	
Greenmount Cemetery	Mar 3	1930
UNDERTAKER	ADDRESS	
A. S. Marshall	3539 Falls Road	

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should RECORD CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54359

CERTIFICATE OF DEATH

101-001 E 54359

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 12-50 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore Cooke 3rd.

(a) RESIDENCE NO. Hopkins Apartment. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of Willie Cooke.

6 DATE OF BIRTH (month, day, and year) March 1, 1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	26	11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Theodore Cooke Jr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mae E. Clark.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Dr. Theodore Cooke, Jr.
(Address) Hopkins Apartments.

15 Filed MAR 2 - 1930 C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

3/1, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	March 3 1930
20 UNDERTAKER Henry Jenkins Son & Co	ADDRESS Govt Position

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Dr Murgatroyd 25 E. Barclay St

E 54560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 54560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2626 Matthews St. 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey E. Valentine

(a) RESIDENCE NO. 2626 Matthews ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or ~~WIFE~~ of) Mary Valentine

6 DATE OF BIRTH (month, day, and year) 5/11/1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer 30

(b) General nature of industry, business, or establishment in which employed (or employer) Gruwald Mfg Co

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Carlisle Pa

PARENTS

10 NAME OF FATHER James H. Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Emma Plummer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mary Valentine

(Address) 2626 Matthews St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 2nd, 1930, to March 1st 1930, that I last saw h~~e~~ alive on Feb 27th, 1930, and that death occurred, on the date stated above, at 630 A m.

The CAUSE OF DEATH* was as follows:

Acute Coronary Occlusion

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Hypocorelitis and Arteriosclerosis

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo Murgatroyd M.D., M. D.

3/1/, 1930 (Address) 1406 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 3/4/ 1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

MAR 2 1930 H. LINCOLN WHITE, M.D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

00/E 54561

E 54561

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No. Gronomand dead at St Agnes Hospital St. 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Schneider

(a) RESIDENCE NO. 3628 Hinkline St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Annie E.

6 DATE OF BIRTH (month, day, and year) 2/9/1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	0	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Moulder
(b) General nature of industry, business, or establishment in which employed (or employer) Iron
(c) Name of employer S B Sexton

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER George Schneider
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Annie E Schneider
(Address) 3628 Hinkline St

15 Filed 19 H. HAMILTON JONES, M. D. Registrar

MAR 2 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Dropsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Charles Brooke M. D.
(Coroner)

3/1, 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross (Brooklyn) Date of Burial 3/4/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54562 ✓ E 54562

E 54562

CERTIFICATE OF DEATH

94-001

24-34

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hanover & McComas Sts. St., Ward)

2-FULL NAME Catherine Herzberger.

(a) RESIDENCE NO. 1582 Boyle St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Widow.

5a If ~~married~~ widowed, ~~or divorced~~ ~~(or) HUSBAND OF~~ (or) WIFE of George W. Herzberger.

6 DATE OF BIRTH (month, day, and year) April 30, 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	71	9	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Annie D. Eckstock. (daughter)
(Address) 1528 Boyle St.

Filed MAR 2 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

2/28. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudai Hill Cemetery — DATE OF BURIAL 3/4/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Dr. Ogden Carey & Forsyth 56

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54563 ✓ E 54563

CERTIFICATE OF DEATH.

60-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 407 Dumison ST. 20-26 (WARD)

2-FULL NAME Emma L Marriott

(a) RESIDENCE NO. 407 Dumison ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of David Marriott

6 DATE OF BIRTH (month, day, and year) 12/14/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER George Green

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Unknown

14 Informant Geo. E. C. Marriott

(Address) 407 Dumison St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/30

17

I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1930, to March 1, 1930,

that I last saw her alive on March 1, 1930,

and that death occurred, on the date stated above, at 12 4. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Acute Myocarditis

(duration) ... yrs. ... mos. 17 ds.

CONTRIBUTORY (Secondary) Toxic Thyroid.

(duration) 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of None.

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Frank H. Ogden, M. D.

, 19 (Address) 115 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 3/4/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54564

CERTIFICATE OF DEATH

90 E 54564

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 E. 31st ST. 12-50 WARD)

2—FULL NAME Maurice J. Molder

(a) RESIDENCE NO. 406 E. 31st St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida E. Molder

6 DATE OF BIRTH (month, day, and year) Jany 24-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	1-	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) France.

PARENTS

10 NAME OF FATHER Maurice J. Molder

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Mrs Ida E. Molder

(Address) 406 E 31st St.

15 Filed ... 19... (Signature) ... Registrar

MAR 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27-1930.

17 I HEREBY CERTIFY, That I attended deceased from Jany 27, 19 30 to Feb 27, 19 30,

that I last saw him alive on Feb. 26, 19 30

and that death occurred, on the date stated above, at 8 35 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied and Dilated Heart

Last Known. (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Last Known (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of no.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Montell ... M. D.

Feb 28, 19 30 (Address) 395 E. 31st & St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 3/3/ 19 30

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 54565

CERTIFICATE OF DEATH

E 54565

14-001

REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No.) South Baltimore General Hospital WARD
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Annie Evans

(a) RESIDENCE NO. 128 N. Patterson Park Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of William Evans

6 DATE OF BIRTH (month, day, and year) 9/2/1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	65	✓	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Nicolaus
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Elizabeth ——
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gertrude Oberender
(Address) 127 N. Montford Ave

15 Filed MAR 2 - 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-1-30

17 I HEREBY CERTIFY, That I attended deceased from 2-18, 1930, to 3-1, 1930
that I last saw her alive on 3-1, 1930
and that death occurred, on the date stated above, at 9 00 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Terminal Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis? Physical Signs.

(Signed) Joseph B. Kaulfaith, M. D.

19 (Address) South Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL 3/4/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54566

E 54566

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 21-29 WARD)

2-FULL NAME Baby Girl Bury

(a) RESIDENCE NO. 807 W West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-27-30

7 AGE: Years | Months | Days | If LESS than 1 day, hrs. or min. 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

PARENTS

10 NAME OF FATHER George Bury

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Lena Link

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant George Bury

(Address) 807 W. West st

15 Filed C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28 1930

17

I HEREBY CERTIFY, That I attended deceased from 2-27, 1930, to 2-28, 1930, that I last saw h alive on 2-28, 1930, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity (35 weeks).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed) Clarence A. Fisher, M. D.

, 193, (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: 3/3/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 2 1930

Pat

Spec.—2-29-28—L. F. S.—500 Bks.

E 54567 ✓E 54567

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) 1267 Pulaski St (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bridget Benson

(a) RESIDENCE NO. 1237 Knox Court WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John T. Benson

6 DATE OF BIRTH (month, day, and year) Sept 29th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 237

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr J. T. Balla

(Address) 1537 Hanover st

15 Filed ..... 19.. Registrar

MAR 2 - 1930 ... JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2. 28. 30.

17 I HEREBY CERTIFY, That I attended deceased from 2. 26, 1930, to 2. 28., 1930

that I last saw h alive on 2. 27., 1930

and that death occurred, on the date stated above, at 4.30a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 2 days to my knowledge

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward Norris

2.28.1930 (Address) 107 East West St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	3/31 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul st

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54568

E 54568 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1410 McHenry ST., 19-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel A. Moore

(a) RESIDENCE NO. 1410 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Ignatius Moore

6 DATE OF BIRTH (month, day, and year) Feb 1st 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Bauscher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Lillian Swan

(Address) 1420 W. Lombard St

15 Filed MAR 2 - 1930 J. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1930, to Feb 28, 1930, that I last saw h[illegible] alive on Feb. 28, 1930, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Hypertension cardio vascular disease

(duration) (?) yrs. mos ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. H. Triplett, M. D.

, 19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 3/3/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSES OF DEATH must be given in plain terms, so that it may be properly classified. EACH statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 54569

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital 22-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dalia Garner

(a) RESIDENCE NO. 835 Williams Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wesley Garner

6 DATE OF BIRTH (month, day and year) Aug. 5, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73	73	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Samuel Buckmaster

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Tucker

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Wm. H. Garner

(Address) 835 Williams St

15 Filed MAR 2 1930, 19 C. HAMILTON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to March 2, 1930, that I last saw her alive on March 2, 1930 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Hypertension Cardio Vascular Renal

(duration) Not determined yrs.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Not determined yrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Robert, M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury, Calvert Co. Md DATE OF BURIAL 3/2 1930

20 UNDERTAKER Wm. Cook ADDRESS 1217 E Fayette St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54570 — 100-001 — E 54570

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. St. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Van

(a) RESIDENCE NO. 2614 E. Monument St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Van

6 DATE OF BIRTH (month, day, and year) April 17 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
41 42	7	10	13	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bridgeman

(b) General nature of industry, business, or establishment in which employed (or employer) Structural Steel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W. Va

PARENTS

10 NAME OF FATHER Jacob G. Van

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER Susan Bradshaw

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Hosp. Records (Address)

15 Filed ..... 19 ..... Registrar

(R. HAMPSON JONES, M. D.)

R 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/1/1930

17 I HEREBY CERTIFY, That I attended deceased from 2-11-30, 19..., to 3-1-30, 19..., that I last saw h.im alive on 3-1-30, 19..., and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

~~Chronic Osteomyelitis~~

Chronic Osteomyelitis

(duration) 2 yrs. mos. dr.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? City Hosp.

Did an operation precede death? Yes Date of 2-14-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos. A. Dougherty, M. D.

(Address) Jno. B. Murphy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL Aug 4 1930

20 UNDERTAKER Charles L Thomas

ADDRESS 1506 E Fort Ave

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54571 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 129 E 54571

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3802 Ridgecroft Rd. 27-41 WARD)

2-FULL NAME M. Madalen Mauer

(a) RESIDENCE NO. 3802 Ridgecroft Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Milton Mauer

6 DATE OF BIRTH (month, day, and year) Jan 6/1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Rogus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Rose Windel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant J. Milton Mauer
(Address) 3804 Ridgecroft Rd.

MAR 2 - 1930 H. C. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28/30

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1924, to Feb 28/30, 19....., that I last saw h.. alive on Feb 28/30, 19....., and that death occurred, on the date stated above, at 7 Am. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) ..... yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? ..... Date of .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Henry B Kolb, M. D.

(Address) 120 E Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem — DATE OF BURIAL Mar 3 19 30

20 UNDERTAKER Phelps Herwig — ADDRESS 2010 Orleans

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54572

CERTIFICATE OF DEATH.

90 E 54572

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 S. Eden St. 35 WARD)

2-FULL NAME Peter Stammen

(a) RESIDENCE NO. 420 S. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — —

6 DATE OF BIRTH (month, day, and year) Dec. 1/1868

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	2	24.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Conrad Stammen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth --

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Stammen (Address) 420 S. Eden St

15 Filed, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Feb. 28, 1930, that I last saw him alive on Feb. 28, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis + arteriosclerosis -

(duration) ? yrs. mos.

CONTRIBUTORY (Secondary) Acute Myocardial Insuff.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

3/1, 1930. (Signed) Dr. J. Ziegler M. D.

(Address) 2007 E. Baltimore -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul's Cem DATE OF BURIAL Mar 3, 30

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 2 - 1930 E. HAYDEN JONES, M. D.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54573

CERTIFICATE OF DEATH

90 E 54573

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Colgate Creek St. B. & R. Bridge Ward) 8-12

2-FULL NAME Augustus Dubs

(a) RESIDENCE NO. 2243 E. Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. da.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura E. Dubs

6 DATE OF BIRTH (month, day, and year) May 27/186

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
63	11	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Asst. Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) P.R.R. 073
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pa.

PARENTS

10 NAME OF FATHER E. Dubs

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country) Pa

14 Informant Helen Dubs
(Address) 2243 E. Biddle St

15 Filed ..... C. HARRY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 27 1930

17 I HEREBY CERTIFY, That I viewed the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hardening of Coronary Arteries

(duration) ..yrs. 1 mos. ..ds.

CONTRIBUTORY (Secondary) Broken Constitution

(duration) ..yrs. ..mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was an autopsy? Yes

What test confirmed diagnosis? —

(Signed) J. C. Slades, M. D.

1930 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon P.R. Cem	May 3 1930
20 UNDERTAKER Philip Henry	ADDRESS 2016 Eutaw St.

MAY 7 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54574 — CERTIFICATE OF DEATH — 90 ✓ E 54574

1—PLACE OF DEATH — REGISTERED NO. 28-66

CITY OF BALTIMORE: (No.) 1300 Walnut Ave ST. — WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ellen Brenner

(a) RESIDENCE NO. 1300 Walnut Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 63 yrs. 5 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Josiah K Brenner

6 DATE OF BIRTH (month, day, and year) Sept 16 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Lutherburg Maryland

PARENTS

10 NAME OF FATHER William Theiss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lutherburg Maryland

12 MAIDEN NAME OF MOTHER Nancy A. Towner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lutherburg Maryland

14 Informant Mrs Bessie L Brenner

(Address) 1300 Walnut Ave

15 Filed FEB 28 1930, 19 — C. HARVEY JONES, M. D. Registrar

MAR 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to Feb 27, 1930, that I last saw h.w alive on Feb 26, 1930 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marshall O Wentz, M. D.

Feb 28 1930 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Park Cemetery — March 3 1930

20 UNDERTAKER — ADDRESS

Stewart Mortuary — Sale

OF DEATH in plain terms, so that it may be of property clauses. Exact statement important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E. 54575 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 54575

CERTIFICATE OF DEATH. 101-04 P. 54575

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital ST. ..... WARD

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Columbus W. Shipley

(a) RESIDENCE NO. Alpha, Md. ST. ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	/	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Columbus T. Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah N. Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. C. E. Thompson
(Address) Sykesville, Md. R.F.D.

15 Filed MAR 2 1930 19 Registered ..... 19 H. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28 1930, to March 2 1930.

that I last saw h[illegible] alive on March 2 1930

and that death occurred, on the date stated above, at 8-30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic glomerulo-nephritis

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical. Laboratory.

(Signed) S. A. Alessi M. D.

. 19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Springfield Cemetery	Mar 4 1930
20 UNDERTAKER	ADDRESS
Freeburn Bros.	Sykesville

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—8-16-21—5M. F[illegible]

E 54576.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E·54576

CERTIFICATE OF DEATH

118-002

E·54576

1—PLACE OF DEATH Church Home + Infirmary

REGISTERED NO. 845

CITY OF BALTIMORE: (No. Broadway + Fairmount Blvd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte Marie Meyer.

(a) RESIDENCE NO. 2808 Clifton Park Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hermann Meyer 1882

6 DATE OF BIRTH (month, day, and year) Aug 7, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Seyfert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Helen Frederich

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr. Hermann Meyer.
(Address) 2808 Clifton Park Terrace.

15 Filed ... 19... C. [illegible] Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 28, 1930, that I last saw her alive on Feb 28, 1930 and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Obstruction

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of Feb 21, 1930

Was there an autopsy? Feb 27, 1930

What test confirmed diagnosis? Autopsy

(Signed) A. J. E. Akelaitis, M. D.

, 19 (Address) Church Home + Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL March 3, 30

20 UNDERTAKER M. W. E. Dippold

ADDRESS 37 Lan[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E-54577 HEALTH DEPARTMENT—CITY OF BALTIMORE E-54577

E 54577 CERTIFICATE OF DEATH. REGISTERED NO. E-54577

1-PLACE OF DEATH Jenkins Memorial Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1000 Eaton Ave (WARD) 2570

2-FULL NAME Florence D. Wallace

(a) RESIDENCE NO. 100 Hilton Ave ST. Catonsville Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 3rd 1871.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Wm. E. Wallace

11 BIRTHPLACE OF FATHER (city or town) Balt (State or country) Md

12 MAIDEN NAME OF MOTHER Agnes Goff

13 BIRTHPLACE OF MOTHER (city or town) Cumberland (State or country) Md

14 Informant Jenkins Memorial Hosp (Address) 1000 Eaton Ave Balt Md

15 Filed 19 H. BRACK JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1. 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-25, 1927, to 3-1, 1930 that I last saw h[illegible] alive on 3-1, 1930, and that death occurred, on the date stated above, at 2.26 p. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Mar 3 1930

20 UNDERTAKER Henry A. Jenkins Sons — ADDRESS McCulloh & Orchard Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

R2 1930

Spec.—2-29-28—L. F. S.—500 Blks.

E 54578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 54578

E 54578

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals WARD) 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stella Matuszewski

(a) RESIDENCE NO. 1605 Locust ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Works in Candy Factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Matuszewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Jolenta Rutkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Tillie Kurtkowska (Sister)

(Address) 1605 Locust St.

15 Filed APR 2 1930, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to March 2, 1930, that I last saw her alive on March 2, 1930 and that death occurred, on the date stated above, at 5. P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Thrash M.D.

(Address) March 2 1930 Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross R.R. Co.	March 5 1930
20 UNDERTAKER J. W. Rozanski 1930	ADDRESS Fountain Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks. E. 54579.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54579

CERTIFICATE OF DEATH

E 54579. 74-001 E 54570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 2-4 Ward)

2-FULL NAME Julia Rose

(a) RESIDENCE NO. 521 S. Durham St., Ward

(Usual place of abode) Like

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. Rose

6 DATE OF BIRTH (month, day, and year) 1887 May 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	47	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None 037
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER William Weglein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Catherine Reis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Wm. Rose
(Address) 521 S. Durham St

Filed MAR 2 - 1930 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital Report

(Signed) [signature], M. D.

2/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	Feb 3 1930
20 UNDERTAKER	ADDRESS
E. C. Ogazewski	Easton, Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

54580

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54580 — **CERTIFICATE OF DEATH** — 129 — **E 54580**

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST 10-14 RD)

2—FULL NAME Mary E. Owens

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nat Owens

6 DATE OF BIRTH (month, day, and year) Nov Nat Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Little Sisters Poor

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Horace Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Mary Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Little Sisters of the Poor (Address) Preston & Valley

15 Filed MAR 4 1930 C. HAMILTON JONES M. D. Registrar

R 2 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-15-30, 19, to 3-1-30, 19, that I last saw h alive on 3-1-30, 19, and that death occurred, on the date stated above, at 11 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis and Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronco Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) W B Hendrix, M. D.

St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cemetery — DATE OF BURIAL: 3/4/30

20 UNDERTAKER: B. L. Hopping — ADDRESS: Annapolis Md

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54581

CERTIFICATE OF DEATH

E 54581

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 605 S. Paca St. 42-30 Ward)

2-FULL NAME Myrtle Haynie

(a) RESIDENCE NO. 605 S. Paca St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 9 mos. 12 ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis E. Haynie

6 DATE OF BIRTH (month, day, and year) May 16 - 1911

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	18	9	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. J. Martin

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Kohlway

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Louise I. Haynie
(Address) 605 S. Paca St

Filed MAR 2 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Poisoned by Carbon Monoxide Illuminating Gas water heater. Accidental Death

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Feldman, M. D.

3/1. 1930 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 3-3rd 1930

20 UNDERTAKER Bernard C. Hahn — ADDRESS 1000 S. Paca St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54582

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54582

CERTIFICATE OF DEATH

185

E 54582

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1708 Johnson St. St., 24-34 Ward)

2-FULL NAME Benjamin H. Smoot.

(a) RESIDENCE NO. 1708 Johnson St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or WIFE of) Winifred Smoot.

6 DATE OF BIRTH (month, day, and year) August 12, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68	6	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist helper
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER William Smoot.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Bettie Smoot.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Winifred Smoot. (wife)
(Address) 1708 Johnson St.

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 27, 1930 192

17 I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.

Probable accidental fall in the street

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? January 20, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

2/28, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL March 3, 1930

20 UNDERTAKER John J. Fahey Sons — ADDRESS 1318 Light St

MAR - 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54583

CERTIFICATE OF DEATH.

100-01 E 54583

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 N. Exeter St. ST.) 5-8 (WARD)

2-FULL NAME Philip G. LoDato

(a) RESIDENCE NO. 303 N. Exeter St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Sylvester

6 DATE OF BIRTH (month, day, and year) Dec 18 1877

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	52	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) own

(c) Name of employer

9 BIRTHPLACE (city or town) Italy (State or country)

PARENTS

10 NAME OF FATHER Husband

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Samuel G. Lodato (Address)

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 25 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 25, 1930, that I last saw him alive on Feb 25, 1930, and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) —

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hornettini, M. D.

3/1, 1930 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL March 3 1930

20 UNDERTAKER George J. Ruth — ADDRESS 1931 Hoffman

CAUTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 54584

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54584

CERTIFICATE OF DEATH.

REGISTERED NO. 10/30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline Valves ST. 9-18 WARD)

2-FULL NAME Thomas O'Brien

(a) RESIDENCE NO. 1603 Ensor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/11/1850

7 AGE	Years	Months	Days 20	If LESS than 1 day hrs. or min.
	79	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Oil

(b) General nature of industry, business, or establishment in which employed (or employer): Bricklayer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Richard O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. O'Brien

(Address) 1603 Ensor St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-1 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-20, 1930, to 3-1, 1930,

that I last saw h(e) alive on 3-1, 1930,

and that death occurred, on the date stated above, at 10 25 A.M.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bilat. Lobar Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? St. Home 1-29-30

Did an operation precede death? Yes Date of 2-6-30

Was there an autopsy? No

What test confirmed diagnosis? Operation + Clinical

(Signed) M. M. Ludwig M.D. M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem. DATE OF BURIAL 3/5/30. 19

20 UNDERTAKER: Geo. J. Duffy & Bro. ADDRESS 1735 Harford

FILED 1930 HARRY JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54585 ✓ 100-001 E 54585

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 13-59 ST., WARD)

2—FULL NAME Frederick Cooper

(a) RESIDENCE NO. 1525 Retreat ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4 and	28 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas P Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna M. Miller.

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D.C.

14 Informant Mrs Anna M. Miller
(Address) 1525 Retreat St.

15 Filed MAR 3 - 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28-30

17 I HEREBY CERTIFY, That I attended deceased from 2-7-, 19 30, to 2-28, 19 30, that I last saw h[illegible] alive on Feb 25, 19 30 and that death occurred, on the date stated above, at 10 50 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J Leyko, M. D.

2/28, 19 30 (Address) J Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvert Cem

20 UNDERTAKER W J Richardson

DATE OF BURIAL Mar 3 1930

ADDRESS North Ave

If the space provided on the front is insufficient, as may be the case in many important cases, use that on the back. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 54586 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

302 ✓

E 54586

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. 30-69

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Oscar Crane Leek

(a) RESIDENCE NO. 103 Bentalou St. ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary P. Leek

6 DATE OF BIRTH (month, day, and year) Aug 19-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Flushing (State or country) N. Y.

PARENTS

10 NAME OF FATHER Oscar C. Leek

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) New York

12 MAIDEN NAME OF MOTHER Eliza Vande Water

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) New York

14 Informant Mrs. Mary P. Leek (Address) 1435 Bentalou St.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28/30

17 I HEREBY CERTIFY, That I attended deceased from 2/26/30, 19..., to 2/28/30, 19..., that I last saw h alive on 2/28/30, 19..., and that death occurred, on the date stated above, at 9:5 PM m.

The CAUSE OF DEATH* was as follows:

Pulmonary Emphysema

DOE

(duration) 2 yrs. 0 mos. ..... ds.

CONTRIBUTORY (Secondary) Spontaneous Pneumothorax

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) David Turner, M. D.

2/28/30 19 (Address) Mercy Hospital

1/4/30 3/1/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL Mar 3, 30

20 UNDERTAKER Wm J Tickner & Sons — ADDRESS N. & Pa

important. See instructions on back of certificates.

WAR - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2344278 E 54587

CERTIFICATE OF DEATH

21 ✓ E 54587

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 28-67 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elijah T. Beachum

(a) RESIDENCE NO. 5324 Belleville Ave ST., WARD 13 Oralton
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E. Beachum

6 DATE OF BIRTH (month, day, and year) ~~Unknown~~ Nov 25 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Wm. T. Beachum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Crosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 MAR 3 - 1930 Registrar: Wm. H. Jones M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930, to Mar 1st, 1930, that I last saw him alive on Mar 1st, 1930 and that death occurred, on the date stated above, at 5 45 A m.

The CAUSE OF DEATH* was as follows:

Emysipelas

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hedwig Koenig, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 3 1930
20 UNDERTAKER: Wm J Tuckner & Sons	ADDRESS: N & Pa

IMPORTANT. See instructions on back of certificates. Use black ink. Write plainly. Do not fold. Keep flat. Do not write in margins. Do not use pencil. Be sure to answer all questions. Do not leave any blanks. Do not write outside the lines. Do not use abbreviations. Do not use ditto marks. Do not use pencil. Be sure to answer all questions. Do not leave any blanks. Do not write outside the lines. Do not use abbreviations. Do not use ditto marks.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54588

E 54588

CERTIFICATE OF DEATH.

99-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 610 N. Bouldin St. 26-11 WARD)

2-FULL NAME Benjamin Franklin Whittle

(a) RESIDENCE NO. 616 N. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary R. Whittle.

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Benj. Whittle

11 BIRTHPLACE OF FATHER (city or town) A.A. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Casena Kinsenda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Mary R. Whittle (Address) 610 N. Bouldin St.

15 Filed MAR 3 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/14, 1929, to 3/1, 1930, that I last saw him alive on 2/27, 1930, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows: Chronic Bronchitis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Senility (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. P. Hearn, M. D.

3/2, 1930 (Address) 1901 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friendship Cem. Md.

DATE OF BURIAL Mar 3 1930

20 UNDERTAKER Wm. J. Hickner & Sons

ADDRESS North Pa

CAUSE OF DEATH is a matter of fact, not of opinion. Give the disease causing death, or in deaths from violent causes state the means and nature of injury. Do not use the words "Heart failure," "Asthenia," "Exhaustion," "Convulsions," or "Uremia," without stating the primary cause. Deaths must be reported within 24 hours. Burial permit will not be issued until certificate is filed. Physicians are required to report deaths promptly. PENALTY FOR NEGLECT OR REFUSAL TO REPORT, OR FOR FALSE REPORT, IS A FINE OF NOT LESS THAN $20.00 NOR MORE THAN $100.00 FOR EACH OFFENSE. See instructions on back of certificates.

HAMPSHIRE, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 54589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54589

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 N. Lakwood ave ST. 12 WARD)

2-FULL NAME Gaetano Di Salvo

(a) RESIDENCE No. 1120 N. Lakwood ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Gaetano Di Salvo

6 DATE OF BIRTH (month, day, and year) aug 27th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) Self — 037

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Giacomo Labruto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antonia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Gaetano Di Salvo
(Address) 1120 N Lakwood ave

Filed MAR 3 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-24- 1930 to 2-28 1930, that I last saw h alive on 2-28 1930, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Artero sclerosis

(duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam

(Signed) M. V. Stato, M. D.

3-2-1930 (Address) 1112 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 3/3 1930

20 UNDERTAKER Geo J. Ruth — ADDRESS 1735 Harford ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54590

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54590

90 E 54590

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 22-31 STREET) WARD

2-FULL NAME Isaac Minor

(a) RESIDENCE NO. 153 W. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet Minor

6 DATE OF BIRTH (month, day, and year) August 1, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 ?	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hod carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick County

(State or country) Md.

PARENTS

10 NAME OF FATHER Dixon Minor

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Dixon ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed MAR 3 - 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28-30

17 I HEREBY CERTIFY, That I attended deceased from 2-19-30, 19..., to 2-28-30, 19...,

that I last saw h. li. alive on 2-28-30, 19...,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. 4? mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

2-28, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calary Cemtey

DATE OF BURIAL 3/3 1930

20 UNDERTAKER Walter B Spriggs

ADDRESS 399 Hanlay st.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 54591 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 54591

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 N Central ave St 10-14 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eunice M. Fanest

(a) RESIDENCE NO. 707 N. Central ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	S

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 15, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER William Fanest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Magent Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaret Cook (Address) 707 N. Central ave

15 Filed MAR 3 1930 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1930, to Feb 27, 1930, that I last saw her alive on Feb 27, 1930 and that death occurred, on the date stated above, at 8:40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Calvin B LeCompte, M. D.

, 19 (Address) 1113 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Osbourn cemetery — DATE OF BURIAL Mar 3 1930

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54592

CERTIFICATE OF DEATH

E 54592

REGISTERED NO. 74801

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1247 Lamar St 2-29 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clay Lane Kaufman

(a) RESIDENCE NO. 1247 Lamar St ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charlie L. Kaufman

6 DATE OF BIRTH (month, day, and year): Oct 16, 1892

7 AGE: Years 37 | Months 4 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Harry E. Wickwire

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Mary Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Charles L. Kaufman

(Address) 1247 Lamar St.

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-27-30, 19..., to 3/1/30, 19..., that I last saw h alive on 3/1/30, 19..., and that death occurred, on the date stated above, at 11.25 a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac thrombosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J. Finn, M. D.

3/1/30 (Address) 410 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: March 4, 1930

20 UNDERTAKER: Thanowell Dodson

ADDRESS: 3615 Eastern Ave

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

E 54593

CERTIFICATE OF DEATH

E 54593

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201 Union Ave. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjamin B. Burns.

(a) RESIDENCE NO. 3700 Elm Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Hand.

(b) General nature of industry, business, or establishment in which employed (or employer) 046

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER William J. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Martha Lovell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant James Burns.

(Address) 3804 Falls Road

15 Filed APR 3 - 1930, 19... Registrar C. HAMILTON JONES, M. D.

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Feb. 28, 1930, that I last saw h... alive on Feb 28, 1930, and that death occurred, on the date stated above, at 4.05 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) 1 yrs. 2 mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical symptoms

Signed) C. J. Cushwa, M. D.

3/1, 1930 (Address) 322 Reliance Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

DATE OF BURIAL March 1930

UNDERTAKER Thenowetth Son

ADDRESS 345 Chestnut Ave

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54594

E 54594

CERTIFICATE OF DEATH.

REGISTERED NO. 15-65 44

(If death occurred in a hospital of institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3902 Fairfax Rd ST. WARD

2-FULL NAME Frank Frederick Palm

(a) RESIDENCE NO. 3902 Fairfax Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Caroline A. Palm

6 DATE OF BIRTH (month, day, and year) Oct 10-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER F. Palm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs C A. Palm

(Address) 3902 Fairfax Rd

15 Filed in 1930 Part Registrar

MAR 3 - 1930 C. HARRISON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1930, to Feb 28, 1930, that I last saw him alive on Feb 28, 1930, and that death occurred, on the date stated above, at 11P m.

The CAUSE OF DEATH* was as follows:

Incurable Carcinoma of Stomach

about

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

about

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wells S. Kilduff, M. D.

3/3, 1930 (Address) 2720 Fairmont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL Mar 3 1930

UNDERTAKER J. J. Dickerson

ADDRESS Lutz

TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54595

CERTIFICATE OF DEATH

90 ✓ E 54595

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nelson Wally

(a) RESIDENCE NO. 1600 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
male	colored	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Cotton

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant James Thompson
(Address) 1434 Preston St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-1-30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1930, to March 1, 1930,

that I last saw h.im alive on March 1, 1930

and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Cystic degeneration of Kidneys

" Sclerosis

Myocardial degeneration

(duration) about 8 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 3/4 1930

20 UNDERTAKER Samuel K. Hensley ADDRESS 508 Bolton

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54596

CERTIFICATE OF DEATH.

72-30 129 E 54596

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 634 W. Lee (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Trier

(a) RESIDENCE No. 634 W. Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Trier

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52 50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O+O

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Solomon Trier

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Easter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Margaret Trier (Address) 634 W. Lee

15 Filed MAR 3 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2/28/30

17 I HEREBY CERTIFY, That I attended deceased from 1/25, 1930, to 2/28, 1930, that I last saw h alive on 2/28, 1930 and that death occurred, on the date stated above, at 10-45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

+ Nephritis

Contributory (Secondary) Acute Pulmonary Edema (duration) 2 yrs. 3 mos. 3 ds.

Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine + Heart.

(Signed) Dr. [illegible] M. D.

2/1, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Florence S. C. DATE OF BURIAL 3/4 1930

20 UNDERTAKER Samuel J. Hemsley ADDRESS W. Balto

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54597

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54597

31 B 54597

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5304 Anglewood Ave (St.) 27-41 (WARD)

2-FULL NAME Grace V. Taylor

(a) RESIDENCE No. 5304 Anglewood Ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 18/1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Louis T. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Grace V. Groth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louis T. Taylor
(Address) 5304 Anglewood Ave

15 Filed ..... 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28/30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1930, to Feb 28, 1930, that I last saw h[illegible] alive on Feb. 27, 1930, and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical tests

(Signed) Aldyth Engmann, M. D.

3/1/1930 (Address) 613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Mar 3 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

MAR 3 1930 HAMILTON JONES, M. D.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54598

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54598

CERTIFICATE OF DEATH

188-02

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital St. 22-30 Ward)

2-FULL NAME Wilhelmina Bode

(a) RESIDENCE NO. 542 W. Conway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
61	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John C Yeager

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not known

14 Informant Wife Bode
(Address) 110 S. Galloway St

Filed MAR 3 - 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest find that said deceased came to her death
(Inquest, autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Dr Car Acc.

Fracture of L Sft. Femur

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? By Autopsy

What test confirmed diagnosis?

(Signed) G G Shades, M. D.

, 19 (Address) 436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side foe additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 5 1930
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 54599

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54599

CERTIFICATE OF DEATH.

131

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balt. City Hosp. St. 3-59 Ward)

2-FULL NAME August Laubach

(a) RESIDENCE NO. 2518 Salem st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) June 13 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	16	18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 46

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Laubach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jacolina ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record (Address)

15 Filed APR 3 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-1-30 ~~4-12-30~~

17

I HEREBY CERTIFY, That I attended deceased from 1-13, 19 30, to 3-1, 19 30, that I last saw him alive on 3-1, 19 30, and that death occurred, on the date stated above, at 1.49 a.m.

The CAUSE OF DEATH* was as follows:

135

Benign hypertrophy prostate

Cystitis 132 Hydronephrosis 131

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. H. Crumpton, M. D.

3-1, 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL March 4 1930

20 UNDERTAKER George A. Rutt

ADDRESS 1735 Harford

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 54600

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54600

31 E 54600

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 310 E Hamburg 24-33 (Ward)

2-FULL NAME William Giotis

(a) RESIDENCE No. 310 E Hamburg ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 1-1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer not any

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER John Giotis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Mary Bones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Louis Giotis.

(Address) 310 E Hamburg St

15 Filed MAR 3 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1929 to March 2 1930.

that I last saw him alive on March 1- 1930.

and that death occurred, on the date stated above, at 2. a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. several mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. L. Buxton M. D.

3/3 1930 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Mar 3. 1930

20 UNDERTAKER F. A. Sivanson & son.

ADDRESS 703 Hamburg

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HAVEN JOHNS, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54601

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54601

CERTIFICATE OF DEATH

10-081

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. N-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn Martin

(a) RESIDENCE NO. 103 N Poppleton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	7	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Frank Martin

11 BIRTHPLACE OF FATHER (city or town) North Car.
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Mitchell

13 BIRTHPLACE OF MOTHER (city or town) North Car.
(State or country)

14 Informant Carrie Martin
(Address) 103 N Poppleton St

15 Filed MAR 3 - 1930 CHAMPE S. JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1930 to Mar 1, 1930,
that I last saw her alive on Mar 1, 1930
and that death occurred, on the date stated above, at 5 20/a m.

The CAUSE OF DEATH* was as follows:

Lary. Diphtheria

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary) Cerb. Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Intubated Feb 24, 1930 Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical Syn. Culture

(Signed) Myron G. Hall, M. D.

3/11, 1930 (Address) Sydenham Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Mar. 3 1930
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	Schroeder St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 54602

CERTIFICATE OF DEATH

E 54602

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 501 W. Pratt St., Ward) 92-30

2-FULL NAME Frank Drazba

(a) RESIDENCE NO. 501 W. Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Charles Drazba
(Address) 501 W. Pratt St.

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

3/3, 1930. (Address) 273 E. Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Mch 4 1930

20 UNDERTAKER John Grebliunas

ADDRESS 499 S. Pk Ave

Ion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54603

CERTIFICATE OF DEATH

129 E 54603

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1606 Aliceanna ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Wojciechowski

(a) RESIDENCE NO. 1606 Aliceanna ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Wojciechowski

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Frances Wojciechowski
(Address) 1606 Aliceanna

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2-30

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1930, to March 2, 1930

that I last saw him alive on March 2, 1930

and that death occurred, on the date stated above, at 6.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Hypertension

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Szpudrichi, M. D.

(Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary

DATE OF BURIAL 3/6 1930

UNDERTAKER W. F. Cestkowski ADDRESS 1618 Eastern

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54604

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54604

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Odessa Pope

(a) RESIDENCE NO. 1948 Lamon ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 15-24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	5	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER William Hope

11 BIRTHPLACE OF FATHER (city or town) S. C
(State or country)

12 MAIDEN NAME OF MOTHER Ella Smackum

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant William Hope
(Address) 1848 Lamon St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-2-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 21, 1930, to March 2, 1930, that I last saw h.. alive on March 2, 1930 and that death occurred, on the date stated above, at 1 20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Bronchial Cystitis

(duration) about 3 weeks mos. da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of 2-22-30

Was there an autopsy? no Diagnosis Confirmed

What test confirmed diagnosis? Clinical Laboratory

(Signed) Carroll M. St Clair, M. D.

3-2 1930 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Lukes Centerstown

DATE OF BURIAL Mch 4 1930

20 UNDERTAKER Sam'l W. Chase & Son

ADDRESS 400 Mosher

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 54605

REGISTERED NO. 69

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 Calverton Heights Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Matthias

(a) RESIDENCE NO. 2308 Calverton Heights Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Matthias

6 DATE OF BIRTH (month, day, and year) June 2. 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72.	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired-Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Tube Works.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Matthias

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss. Rose L. Matthias

(Address) 2308 Calverton Heights Ave.

15 Filed ..... 19 ..... C. HANSEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2. 1930.

17 I HEREBY CERTIFY That I attended deceased from Feby 22. 1930. to March 2. 1930.

that I last saw him alive on March 1. 1930.

and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Interstitial Sclerosis Chronic Nephritis Old Age (duration) Widespread

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M. L. Spielmeyer M. D.

3/3. 1930 (Address) 182 Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem DATE OF BURIAL Mar 1930.

20 UNDERTAKER Mr. & Mrs. John M. Teufel & Son ADDRESS 601 W. Fayette St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 54606

REGISTERED NO. E 54606

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hosp. ST. 25-72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Edith E. Geary.

(a) RESIDENCE NO. 2726 Washington Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Geary.

6 DATE OF BIRTH (month, day, and year) Nov. 18 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	3	11/3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Wm McKay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Mrs. John F. Teufel. (Address) 501 W. Fayette St.

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 1, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb.-26, 1930, to Mar 1, 1930, that I last saw h alive on Mar 1, 1930 and that death occurred, on the date stated above, at 2 00 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2726 Washington Blvd.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edwin J. Pordyce, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mar 4, 1930.

20 UNDERTAKER Mr. & Mrs. J. W. Teufel & Son — ADDRESS 501 W. Fayette

3-1930. [illegible]

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 54607

CERTIFICATE OF DEATH

E 54607

1—PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital WARD) 29

2—FULL NAME William B Barry

(a) RESIDENCE NO. 844 W Pratt ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 11 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed or divorced HUSBAND of (or) ~~WIFE of~~ Frances M. Barry

6 DATE OF BIRTH (month, day, and year) April 7-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill wright

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Barry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Margaret Lavery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Frances M Barry

(Address) 844 W Pratt St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1930, to March 2, 1930; that I last saw h[illegible] alive on March 2, 1930 and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar

(duration) ... yrs. ... mos. 2 da.

CONTRIBUTORY (Secondary) Chronic Ulcer

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 2-19-30

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. C. Fortin Jr. M. D.

19 (Address) Frederick Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	3/5/ 1930
20 UNDERTAKER John J Cowan & Son	ADDRESS 901 Hollins St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 54608

CERTIFICATE OF DEATH

E 54608

REGISTERED NO. 15 59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) President Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mabel Gaskins

(a) RESIDENCE NO. 1615 Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19 20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic (cook) 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Al Gaskins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Adie Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lillie Gaskins (Address) 1615 N. Carey St

15 Filed MAR 3 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28-30

17

I HEREBY CERTIFY, That I attended deceased from Feb 21, 19 30, to Feb 28, 19 30,

that I last saw her alive on Feb 28, 19 30,

and that death occurred, on the date stated above, at 4 20 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Bilateral)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical + X-ray

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) President Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cemetery — DATE OF BURIAL: Mar 3 1930

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Pennsylvania

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54609 ✓ 49 E 54609

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. George J. Burch

(a) RESIDENCE NO. 4513 Mansfield ST. Cwa WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie B Swann Burch

6 DATE OF BIRTH (month, day, and year) Feb 27 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer Church Home & Infirmary

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER James J. Burch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sallie Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Clayton G. Burch

(Address) 210 E. Federal St

15 Filed MAR 3 - 1930 Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/9, 1930, to 3/1, 1930, that I last saw h[illegible] alive on 3/1, 1930 and that death occurred, on the date stated above, at 6:20 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of pancreas

Unknown (duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Complete obstruction

jaundice (duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem findings

(Signed) W. W. Elgin, M. D.

3/1, 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL March 4 1930

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W. North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 54610

REGISTERED NO. E 54610

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 1/2 East ST. 76-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Philip Hilty

(a) RESIDENCE NO. 35 1/2 East ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nora Hilty

6 DATE OF BIRTH (month, day, and year): June 26 1874

7 AGE: Years 55 | Months 8 | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Building Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): 016

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: John Hilty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Allbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Mrs. Nora Hilty (Address) 35 1/2 East St.

15 Filed MAR 3 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930, to March 1, 1930, that I last saw him alive on Feb. 28, 1930, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis.

Acute Myocarditis.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis (duration) 4 yrs. 6 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Hemoglobin Examination

What test confirmed diagnosis?

(Signed) C. E. Hoffman M. D.

(Address) 3508 East Ave. 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Mar 3 1930

20 UNDERTAKER: Hughes & Jones Inc — ADDRESS: 441 Broadway

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 54611

E 54611

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2809 Overland Ave. ST. 27-44 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Johnson Bowen

(a) RESIDENCE NO. 2809 Overland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

(a) If married, widowed, or divorced
(or) WIFE of Daniel Lee Bowen

6 DATE OF BIRTH (month, day, and year) Jan. 27, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER Grafton Johnson

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Gorsuch

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Maryland

14 Informant Daniel Lee Bowen

(Address) 2809 Overland Ave.

Filed MAR 3 1930 19 HAMBLETON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March. 1. 1930

17 I HEREBY CERTIFY, That I attended deceased (from Apr 27, 1930, to March 1, 1930

that I last saw h... alive on March 1, 1930

and that death occurred, on the date stated above, at 10;20 A.m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Myocarditis + Arteriosclerosis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Lankenau, M. D.

March 1, 1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Mch. 4/30 19
20 UNDERTAKER	ADDRESS
Hughes & Mc Clure	424 N. Broadway

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 54612 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54612

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp. ST. 16-68 WARD)

2-FULL NAME Mrs. Dorothy Koenig

(a) RESIDENCE No. 1141 Poplar Grove St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced (or) WIFE of Ed Koenig

6 DATE OF BIRTH (month, day, and year) Sept 6, 1887.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
42	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Fred. L. Volz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary L. Menke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Ed Koenig

(Address) 1141 Poplar Grove St

15 Filed , 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 1 - 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-25, 1930, to 3-1, 1930,

that I last saw her alive on 3-1, 1930

and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

acute appendicitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of March 1-30

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Ernest Spencer Jr. , M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 4/4/1930

20 UNDERTAKER H. C. Brauning Sec. ADDRESS 1136 Poplar Grove St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 54613 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54613

CERTIFICATE OF DEATH.

1637-802

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hosp. St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Bottman

(a) Residence No. 531 Oxford St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced (write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Feb 22, 1930

7-AGE: ..... yrs. ..... mos. ..... ds. If LESS than 1 day, 14 hrs. or 10 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: INFANT

(b) General nature of industry, business, or establishment in which employed (or employer): Old

(c) Name of employer: N. Univ. Hosp.

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md

PARENTS

10-NAME OF FATHER: Alec Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country):

12-MAIDEN NAME OF MOTHER: Joanette Bottman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Maryland

14-(Informant) Body Retained By

(Address) University of Maryland

15-Filed MAR 3 1930 16-[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Feb. 22-1930

17-I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930 to Feb 22, 1930, that I last saw him alive on Feb 22, 1930, and that death occurred, on the date stated above, at 4 10 P.M.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prolonged Labor

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes (Sub-Dural Hemorrhage)

What test confirmed diagnosis? Clinical & Pathological

(Signed) [illegible] M. D.

[illegible] 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: FETUS RETAINED BY

DATE OF BURIAL, ... 19....

20-UNDERTAKER: Univ. of Maryland

ADDRESS

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54614

CERTIFICATE OF DEATH

90

REGISTERED NO. E 54614

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at Hopkins Hospital

City of Baltimore: (No. 59 St. Ward)

2-FULL NAME Unknown

(a) RESIDENCE NO. Found in front- 20 N. Spring St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
about	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant N.E.Dist Police
(Address)

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 10/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardip-Renal Disease

(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

2/29/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER
[illegible]

ADDRESS
MAR 3 - 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

53

1406 THE

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54615

CERTIFICATE OF DEATH

E 54615

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St.) 24-33

2-FULL NAME Dorsey Savage. (C)

(a) RESIDENCE NO. Pocomoke City, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	68	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pocomoke City Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Hospital Report.
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus.
Gangrene.
Amputation of left leg Feb. 24, 1930
(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Pocomoke City, Md
Did an operation precede death? Yes. Date of Feb. 24, 1930
Was there an autopsy? No.
What test confirmed diagnosis? Clinical Diagnosis
(Signed) Otto M. Reinhardt M. D.
2/28, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

MAR 3 - 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

14 4101 THE

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54616

CERTIFICATE OF DEATH

59-002

E 54616

22-31

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 121 Seldner Place. St. Ward)

2-FULL NAME Sylvania James.(C)

(a) RESIDENCE NO. 121 Seldner Place St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) December 20, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Alexander James.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Willie Jones.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) A.A.Co. Md.

14 Informant Willie Jones.(C) mother.
(Address) 121 Seldner Place.

15 Filed MAR 3 - 1930 C. HA[illegible] Registrar

1107 Nbr

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency.
Congenital.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leonhardt, M. D.

3/3, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health

MAR 3 — 19

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54617

CERTIFICATE OF DEATH.

90 E 54612

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 641 George ST. 17-25 (WARD)

2-FULL NAME Charles Allen

(a) RESIDENCE NO. 641 George ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Exp of Billiard Parlor

(b) General nature of Industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Bannick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elanie Edens

(Address) 1231 Bayard St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 27 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to Feb 27, 1930, that I last saw h[illegible] alive on Feb 26, 1930, and that death occurred, on the date stated above, at 6 4 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. ? mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3-1, 1931 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Mar 3 1930

20 UNDERTAKER [illegible]

ADDRESS 2325 Madison Ave

IMPORTANT—Before signing, READ CAREFULLY the above certificate, and see that it is correct in every particular. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54618

CERTIFICATE OF DEATH.

73 E 54618

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 20-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Tschuckardt

(a) RESIDENCE NO. 3135 Strickland St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19- 82

7 AGE: Years 47 | Months 9 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 079

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Tschuckardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie F. Stahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) August Tschuckardt 3135 Strickland St

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 2 1930

17 I HEREBY CERTIFY, That I attended deceased from 2 - 19 1930, to 3 - 2 1930, that I last saw alive on 3 - 2 1930, and that death occurred, on the date stated above, at 8 [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Transverse Myelitis

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Infected decubitus ulcer

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Mar. 5 1930

20 UNDERTAKER: Josiah Lyter

ADDRESS: 1600 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54619

23446 E 54619

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32x

E 54619

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie Gatsey

(a) RESIDENCE NO. Wardman Apts. ST. 46th WARD 8th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 14-1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U S -

PARENTS

10 NAME OF FATHER Deceased

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unk

12 MAIDEN NAME OF MOTHER Edna Lacey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md -

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 3 - 1930 J. HARRY [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 25-, 1930, to March 1, 1930, that I last saw her alive on March 1, 1930, and that death occurred, on the date stated above, at 9 a- m.

The CAUSE OF DEATH* was as follows:

Meningitis, tuberculous

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. O. G. Warren, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pat Lawn Cem

DATE OF BURIAL Mar 4 1930

20 UNDERTAKER Geo M. Fritchie

ADDRESS 61 N Wolfe

IMPORTANT—DEATH in plain terms, so that it may be properly classified. Cause of death must be important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

E 54620

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54620

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH St agnes Hospital

CITY OF BALTIMORE: (No. 19-28 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert Smith

(a) RESIDENCE NO. 1610 Hollins St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? 64 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Smith

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 72 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer): St Blaincott

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Noah Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Emma Burgess

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs Enduvible

(Address) Amerstan Washington Dr

15 Filed MAR 3 1930 19 C. HAMPSON JONES, M. [illegible]

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-1 1930

17

I HEREBY CERTIFY, That I attended deceased from 2-24-30, 1930 to 3-1, 1930

that I last saw him alive on 3-1, 1930,

and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? yes Date of 2-27-30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Ernest Spencer Jr., M. D.

, 19 (Address) St agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] DATE OF BURIAL: March 4 1930

20 UNDERTAKER: Edward Evans ADDRESS: 386 Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Heenan

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54621

CERTIFICATE OF DEATH

74-001

E 54621

1—PLACE OF DEATH

REGISTERED NO. 9-46

CITY OF BALTIMORE: (No. University Hospital, (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Heenan

(a) RESIDENCE NO. 2306 Liberty ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of ~~(or) WIFE of~~: John Heenan

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 55 | Months — | Days — | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Michael Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary E. Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Holland

14 Informant: Joseph M. Smith

(Address): 2626 E. Balto. St.

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 2 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930 to March 2, 1930

that I last saw h.. alive on March 2, 1930

and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Confluent Bronchio pneumonia

(duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) pneumonia

(duration) ...yrs. ...mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hosp.

(Signed) W. H. Varney M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Mar 5 1930

20 UNDERTAKER: Chas. P. Crane & Son

ADDRESS: 1180 N. Royal Ave

Plot

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54622

21 E 54622

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph H. Cullen

(a) RESIDENCE NO. 1632 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Claim Adjuster

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer United Railways & E. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Simon V. Cullen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Caroline Knowles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Vincent Cullen (Brother)

(Address) New York City

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1930, to March 2, 1930, that I last saw him alive on March 2, 1930 and that death occurred, on the date stated above, at 10 15 A. m.

The CAUSE OF DEATH* was as follows:

Erysipelas of Face (Idiopathic)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Free, M. D.

3/2, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/4 1930

20 UNDERTAKER Chas. F. Love Son

ADDRESS Mt. Royal Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54623

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 54623

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2519 Frederick ave ST., 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Elizabeth Stroh

(a) RESIDENCE NO. 2519 Frederick ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Stroh

6 DATE OF BIRTH (month, day, and year) July 18-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	7	11	13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Getz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elizabeth Hazelton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles A. Stroh

(Address) 2001 West Baltimore Street

15 Filed ..., 19 ... Registrar

MAR 3 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mon 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Mar 1, 1930, that I last saw h[illegible] alive on Feb 28, 1930 and that death occurred, on the date stated above, at 845A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2694 Dulaney St

Did an operation precede death? Yes Date of Aug 22-30

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & pathological findings

(Signed) A. E. Hatfield, M. D.

Mar 3 1930 (Address) Maple Ave & Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 3/4 1930

20 UNDERTAKER Ga. Watson & Son 2503 Edmondson ave

ADDRESS

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 54624

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54624

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 434 E. 22nd St. St., (Ward)

2—FULL NAME William Joseph Wiseman.

(a) RESIDENCE NO. 434 E. 22nd St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Corrinne Wiseman.

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	21 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Barber Shop

(c) Name of employer Owner of shop.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William V. Wiseman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Holler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Annie C. Wiseman.
(Address) 434 E. 22nd. St.

15 Filed 3 - 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1930, to March 1, 1930, that I last saw h[illegible] alive on March 1, 1930 and that death occurred, on the date stated above, at 6.20 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. mos. days

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

(duration) yrs. mos. 25 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas D. White, M. D.

19 (Address) 532 E. 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: 3/5/1930

20 UNDERTAKER: C. Vernon Lemmon

ADDRESS: 4513 Park Heights Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

E 54625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-007 E 54625

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Edgewood st. ST. 20-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Donald Fitzberger

(a) RESIDENCE NO. 510 Edgewood St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2yrs. 3 mos. 17ds. How long in U. S., if foreign Birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	2	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Harry Fitzberger

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Edna M. Mills

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Mills
(Address) 510 Edgewood St

15 Filed MAR 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/1/30

17 I HEREBY CERTIFY, That I attended deceased from 2/1/30, 19..., to 3/1/30, 19 30.

that I last saw h[illegible] alive on 3/1/30, 19...

and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Hurst, M. D.

, 19 (Address) 1341 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	3/4 1930
20 UNDERTAKER	ADDRESS
J. Fred McCully	1852 Fort Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

181-001

E 54626

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1115 Proctor St. 10-14 (Ward)

2-FULL NAME Jerome M. Butler

(a) RESIDENCE NO. 1115 Proctor St., Ward

(Usual place of abode) (if non-resident give city or town and State):

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	divirced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6/1869

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	60	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Steam Boat Enguneer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Jerome Butler (son)
(Address) 815 Cator Ave

15 Filed MAR 3 - 1930 16 C. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28/30 ?

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation Accidental, Water in two vessels probably boiled over ad put out gas stove bur(ners) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. O. Brown, M. D.

3/3/30 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 3/4 1930

20 UNDERTAKER: John Ulrich

ADDRESS: Orleans St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state C... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54627

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54627

CERTIFICATE OF DEATH

160

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 of Baker ST. 15-71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Talley

(a) RESIDENCE NO. 6 of Baker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/16/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
13 Days Old.			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt., Md.

PARENTS

10 NAME OF FATHER Moses Talley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie Talley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mother

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 THOMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-1-30.

17 I HEREBY CERTIFY, That I attended deceased from 2-16, 1930, to 3-1, 1930, that I last saw her alive on 3-1, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Examination

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Stacy, M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAR 3 - 1930 19

20 UNDERTAKER Commissioner Health.

ADDRESS

important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54628 ✓ 46 E 54628

E 54628

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2705 Barclay (Ward) 17-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary A Morgan

(a) RESIDENCE NO. 2705 Barclay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth 70 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andw J. Morgan

6 DATE OF BIRTH (month, day, and year) Dec 8 [illegible].

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) England

(State or country)

PARENTS

10 NAME OF FATHER Patrick J. Fenn

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Madden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Beatrice Payne

(Address) 2705 Barclay St

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1 1930 to March 2 1930 that I last saw her alive on March 2 1930 and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri & Colon

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Signs & Physical

(Signed) Jas L. Hooper M. D.

3/3 1930 (Address) 862 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross - H. Road

Date of Burial Mar. 6 1930

20 UNDERTAKER J Fay Burns Sons

ADDRESS Towson

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R3 - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54629

90 E 54629

CERTIFICATE OF DEATH

REGISTERED NO. 13-57

1—PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME E. Eugene Baker

(a) RESIDENCE NO. 3509 Roland Ave ST. 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 2 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Baker

6 DATE OF BIRTH (month, day, and year) Dec 14-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	2	15+1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam-fitter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 3½ years 060

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John T. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Sears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Anna M. Baker

(Address) 3509 Roland Ave.

15 Filed MAR 8 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15 1930, to Mch 1, 1930, that I last saw h[illegible] alive on Mch. 1 1930 and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Phlebitis 3 yrs - Intestinal Obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Evan J Kelly, M. D.

3/12 1930 (Address) 608 Somerset Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	March 5 1930
20 UNDERTAKER Horace K. Burgee	ADDRESS 3631 Falls Road

important. See instructions on back of certificates.

Spec.—2-29-25—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54630

91-002

E 54630

CERTIFICATE OF DEATH

REGISTERED NO. 9-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apts. ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Ambach

(a) RESIDENCE NO. Esplanade Apts. ST. [illegible] A. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Ambach

6 DATE OF BIRTH (month, day, and year) Feb 19 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	0	12	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Samuel Ambach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. A. Ambach

(Address) Esplanade Apts.

15 Filed [illegible], 19 [illegible] Registrar

C. HARRISON JONES, M. D.

MAR 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1930, to March 2nd, 1930, that I last saw h[illegible] alive on March 2nd, 1930 and that death occurred, on the date stated above, at 2.20 A. m.

The CAUSE OF DEATH* was as follows:

Generalized Arterio Sclerosis (Senility)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypo Static Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Michael N Strauss, M. D.

III. 3, 1930 (Address) 1360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 3/5/1930

20 UNDERTAKER David Sonnheim

ADDRESS 18-20 W. Mt. Royal Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54631

CERTIFICATE OF DEATH

89

E 54631

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 Eutaw Place ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sigmund Kann

(a) RESIDENCE NO. 1321 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude S. Kann

6 DATE OF BIRTH (month, day, and year) June 8th. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	8	22 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dept. Store Prop. 042

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Solomon Kann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Fleischmen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Solomon Kann

(Address) 1321 Eutaw Place

15 Filed MAR 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1930.

17 I HEREBY CERTIFY, That I attended deceased from FRIDAY FEBY 28 1930, to MARCH 2d, 1930, that I last saw him alive on MARCH 2d, 1930 and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

ANGINA PECTORIS (CORONARY ARTERY THROMBOSIS)

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) ARTERIOSCLEROSIS SYMPTOMS (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P Hamburger, M. D.

Mar 3. 1930 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cem.

DATE OF BURIAL Mch. 4, 1930

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 54632

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Mary Margaret Marrow

(a) RESIDENCE NO. Church Home & Infirmary ST. [illegible] WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 11 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 11, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas. F. Marrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nannette Light

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant J. Frank Forrester

(Address) 3 S. Sarentaeum ave. Catonsville Md

15 Filed MAR 3 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 23, 1930, to March 3, 1930

that I last saw her alive on March 2, 1930

and that death occurred, on the date stated above, at 2.10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis and chronic nephritis on arteriosclerotic basis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Post mortem findings

(Signed) H. H. Slye, M. D.

3/3, 1930 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Mch 4 1930

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1924 W. North ave

important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Bks.

Gibbons ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54633 REGISTERED NO. E 54633

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3403 St. Ambrose St., 27-57 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Genevieve Gibbons

(a) RESIDENCE NO. 3403 St. Ambrose St. WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas F. Gibbons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margaret A. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Thomas F. Gibbons

(Address) 3403 St. Ambrose Ave.

Filed MAR 3 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1930, to March 3, 1930, that I last saw h[illegible] alive on March 3, 1930 and that death occurred, on the date stated above, at 8.00 A m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Scarlet fever

(duration) — yrs. — mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Lucy E. Olds, M. D.

3-3, 1930 (Address) 1203 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 3/4/30

UNDERTAKER Temple & Staley

ADDRESS Fayette

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 54634 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54634

CERTIFICATE OF DEATH.

REGISTERED NO. 45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland ST. 46-37 WARD)

2-FULL NAME Mrs. Bessie Westgate

(a) RESIDENCE NO. 507 S. Lappolla ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Westgate

6 DATE OF BIRTH (month, day, and year): July 25, 1875

7 AGE: Years 54 Months 7 Days 6 If LESS than 1 day, hrs. or min. 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Samuel Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Sarah McCloud

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Mrs. Viola Riley (Daughter)

(Address) 4634 Belair Road

15 Filed C. HAMPSON JONES, M. D. Registrar

Rec'd

R3-7030

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-27, 1930, to 3-1, 1930, that I last saw h[illegible] alive on March 1, 1930 and that death occurred, on the date stated above, at 6:35 P m.

The CAUSE OF DEATH* was as follows:

acute cardiac failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of int. tract.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Michael Gordon M. D.

Mar 1, 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: Mar 4 1930

20 UNDERTAKER: Henry Sander & Sons. Inc.

ADDRESS: Baltimore St & Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54635 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54635

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 S. Ellwood Ave ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME GEORGE M. LIDARD

(a) RESIDENCE NO. 320 S. Ellwood Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha A. Lidard

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1858

7 AGE	Years	Months	Days 24	If LESS than 1 day, ...hrs. or ....min.
	71	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Resteranteur

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Moses Lidard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Delia Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Lydia C. Castor

(Address) 320 S. Ellwood Ave.

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

APR 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1930, to March 2, 1930, that I last saw h. ~~in~~ alive on March 1, 1930 and that death occurred, on the date stated above, at 4.10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, Arteriosclerosis

unknown

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ....yrs. ....mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) James E Peterman, M. D.

(Address) 1224 S. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: Mar. 5. 1930

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: Baltimore St. & Broadway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54636

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54636

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2213 Fleet ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME JOHN S. MASETH

(a) RESIDENCE NO. 2213 Fleet ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) June 13, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	8	12 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Ob

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER John S. Maseth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Trager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. George Maseth (Brother

(Address) 2213 Fleet St.

Filed 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1930, to March 1, 1930, that I last saw him alive on Feb. 28, 1930 and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

No (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Valvular Dis Heart

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chas Strum, M. D.

3/3/30 (Address) 4055 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: Mar. 4 1930

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: Baltimore St & Broadway

3 important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54637.

CERTIFICATE OF DEATH

90 E 54637

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 N. Linwood Ave. ST. 6-11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CHRISTINA RAUCH

(a) RESIDENCE NO. 120 N. Linwood Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? 37 yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Rauch

6 DATE OF BIRTH (month, day, and year): Sept. 24 1841

7 AGE: Years 88 | Months 5 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Krumm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Ruebsam

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Sophie M. Coburn (Daugh[ter])

(Address) 120 N. Linwood Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1928 —, 19..., to March 2—, 1930,

that I last saw h[er] alive on March 2nd, 1930

and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Degenerative Myocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harris J. Johnson M. D.

19 (Address) 452 East Eastern Ave - City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

21 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar. 5 1930
20 UNDERTAKER: Henry Sander & Sons, Inc.	ADDRESS: Baltimore St & Broadway.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54638 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54638

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. 2905 N.Calvert ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Conrad Distler Jr.

(a) RESIDENCE NO. 2905 N.Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

a If married, HUSBAND of Elizabeth E.Distler

6 DATE OF BIRTH (month, day, and year) Mch.22,1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Allegheny Pa.

PARENTS

10 NAME OF FATHER: John C.Distler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr.Carl Distler
(Address): 2905 N.Calvert St.

15 Filed R3 - 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb.28.1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 28—, 1930, to Feb 28—, 1930, that I last saw him alive on Feb 28—, 1930 and that death occurred, on the date stated above, at 4;30 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

2 hours
(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? ✓

(Signed) Jefferies Bruce M. D.

3/3, 1930 (Address) 5 Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: Mch.4/30 19

20 UNDERTAKER: Hughes & Jones Inc

ADDRESS: 424 N.Broadway

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

E 54639

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 54639

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Good Shepherd Convent

City of BALTIMORE: (No.) Mount & Hollins St. (Ward) 19-28

2-FULL NAME Josephine Tamony

(a) RESIDENCE NO. Mount & Hollins St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 Color or Race W

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~ Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4th 1865

7 AGE Years 64 Months 9 Days 27 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious 65

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alexandria

(State or country) Va

PARENTS

10 NAME OF FATHER William Tamony

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Maria Murphy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Superioress

(Address) Mt & Hollins Sts

Filed 1930 C. HAMPSON JONES, M. D. 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1st 1930 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1925, to March 1st 1930, that I last saw h.. alive on March 1st 1930, and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows: Acute dilatation of heart (duration) 2 yrs. mos. ds.

Myocardial degeneration

CONTRIBUTORY (Secondary) Arterio-sclerosis (duration) 5 yrs. mos. ds.

18 Where was disease contracted —

If not at place of death!

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) J. A. Cleland, M. D.

(Address) 130 W Centre St

March 1st 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cemetery Date of Burial 3/4 1930

20 UNDERTAKER John J. Fahey & Sons ADDRESS 318 Light St

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54640

101-001

E 54640

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2526 E. Monument ST., 9-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie H. C. Orem

(a) RESIDENCE NO. 2526 E. Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 3 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry H. Orem

6 DATE OF BIRTH (month, day, and year): Nov 10. 1858

7 AGE: Years 71 | Months 3 | Days 19 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Lewis H. Buckenmeister

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rachel L. Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Henry H. Orem

(Address) 2526 E. Monument St

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

R 3 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930, to March 1, 1930

that I last saw her alive on March 1, 1930

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) 1 wk ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Richardson M.D.

March 4 1930 (Address) 112 W. 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery — DATE OF BURIAL: March 4 1930

20 UNDERTAKER: H. S. Hyphant — ADDRESS: 850 W. Baltimore St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 54641

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Rose F. Alford

(a) RESIDENCE NO. Lake Shore 2nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	W	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Alonzo F. Alford

6 DATE OF BIRTH (month, day, and year) June 18. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
50	50	1	16	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Eastern Shore Md.

PARENTS

10 NAME OF FATHER Murray Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Rose Harding

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Records (Address)

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to Mar. 3, 1930

that I last saw h[illegible] alive on Mar. 3, 1930

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Broncho Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) ? yrs. 1 hr. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 3/5/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

MAR 3 - 1930

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Paul L. Linde

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

E 54642

CERTIFICATE OF DEATH

E 54642

1—PLACE OF DEATH South Baltimore General Hospital

CITY OF BALTIMORE. (No. ____ St., ____ WARD)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul L. Linde

(a) RESIDENCE NO. 1519 N. Bentalou ST., ____ WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) April 12, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	63	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Fire Department

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Linde

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Unknown

14 Informant Mrs. Lula Linde
(Address)

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-28-30

17 I HEREBY CERTIFY, That I attended deceased from 2-15, 1930, to 2-28, 1930, that I last saw ~~him~~ alive on 2-28, 1930 and that death occurred, on the date stated above, at 8 40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ____ yrs. ____ mos. 13 ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph B. Faulkaitis, M. D.

2/28 1930 (Address) South Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL March 4 1930

20 UNDERTAKER Harry N. Witzke, 4101 — ADDRESS Edmondson Ave.

Important. See instructions on back of certificates.

C. HAMPSON JONES, M

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54643

CERTIFICATE OF DEATH

74 981 V

E 54643

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 324 S. Mount St. 19-28 Ward)

2-FULL NAME George J. Fitzer Sr

(a) RESIDENCE NO. 324 S Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Fitzer

6 DATE OF BIRTH (month, day, and year) Apr 5 1867

7 AGE	Years	Months	Days 26	IF LESS than 1 day ..... hrs. or ..... min.
	62	10	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pa
(State or country)

PARENTS

10 NAME OF FATHER John Fitzer

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Mary E. Fitzer
(Address) 324 S. Mount

15 Filed R 3 - 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles B Brooke, M. D.

3/2, 1930 (Address) 3601 3-h

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3/4 1930

20 UNDERTAKER Harry A Witzke

ADDRESS 401 Lin...

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54644 ✓ 199 E 54644

E 54644

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Jos Hosp. St., 9-17 (Ward)

2-FULL NAME John C Schaefer

(a) RESIDENCE NO. Silver Spring Road St., Fallston Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elis Schaefer

6 DATE OF BIRTH (month, day, and year) 3-26-1878

7 AGE	Years	Months	Days 6	IF LESS than 1 day ... hrs. or ... min.
	51	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer 050

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Henry Schaefer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Johanna Brecht

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Elizabeth Schaefer
(Address) Silver Spring Rd. Fallston

15 Filed ..., 19... Registrar

MAR 3 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Struck & Knocked down by automobile driven (not apprehended) by policeman
Coma (duration) ... yr. ... mos. ... ds.
CONTRIBUTORY (Secondary) Concussion Chest
Traumatic Shock (duration) ... yr. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Belair Rd Nr Fullerton

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin

(Signed) H J Haun, M. D.

3/3 1930 (Address) 2139 W. Eldey

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	3/5/30
20 UNDERTAKER Harry A Wetzke	ADDRESS 4101 Edmondson Ave

IMPORTANT.—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54645

E 54645

CERTIFICATE OF DEATH.

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Smith St. H6-23 WARD)

2-FULL NAME Elizabeth Walty

(a) RESIDENCE NO. 1311 Smith St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	Col	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Raymond Walty (Address) 1311 Smith st

15 MAR 4 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) mar 1/30

17 I HEREBY CERTIFY, That I attended deceased from Feby 11, 1930, to mar 1, 1930,

that I last saw her alive on mar 1, 1930

and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) —

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward E. Raynor, M. D.

3/4, 1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cross Roads

DATE OF BURIAL 3-7 1930

20 UNDERTAKER Daniel Easton

ADDRESS 911 Paca

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54646 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54646

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. M-24 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sylvester Traynham

(a) RESIDENCE NO. 570 Camel st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Traynham

6 DATE OF BIRTH (month, day, and year) Jan. 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	/		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Traynham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 19 30, to Feb. 28, 19 30, that I last saw him alive on Feb. 28, 19 30 and that death occurred, on the date stated above, at 6.55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jas Stroud Jr. M. D.

3-1-, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

UNDERTAKER Dent & Easton

DATE OF BURIAL 3-4-30

ADDRESS 966 Edmondson Ave

Important. See instructions on back of certificates.

MAR 4 1930 CLAYTON JONES M

Spec.—2-29-28—L. F. S.—500 Blks.

E 54647

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54647

CERTIFICATE OF DEATH

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Pierce ST. 19-27 WARD)

2—FULL NAME Edward Adams

(a) RESIDENCE NO. 1708 Pierce ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1879 - July 20

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edw Adams

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Laura Green

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Alice Gordon

(Address) 1708 Pierce

15 MAR 4 - 1930 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930 to Mar 1st, 1930 that I last saw h[illegible] alive on Mar 1st, 1930 and that death occurred, on the date stated above, at 11-30 m.

The CAUSE OF DEATH was as follows:

Edema of Intestinal Nephritis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY .....

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) H. H. Hicks, M. D.

(Address) Mount Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mommy Dear Cem	3-4 1930
20 UNDERTAKER Richard Carter	ADDRESS 916 Pace

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54648

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54648

CERTIFICATE OF DEATH

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 711 W. Carrollton St. 16-23 Ward)

2-FULL NAME Oral F. Bundy.

(a) RESIDENCE NO. 711 W. Carrollton Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3-1930

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Earl Roberts

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mae Bundy

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Rose Bundy
(Address) 711 W. Carrollton

15 Filed ... 19... Registrar Balto.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) H. Bloch, M. D.

Mar 7 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See ceverse side foc additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 3-4 1930

20 UNDERTAKER Daniel Eaton

ADDRESS 916 Cal

Be sure and be careefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec— 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54649 ✓ 129 E 54649

E 54649

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1408 Whitelock St. St. 13-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline E. Powell

(a) Residence No. 1408 Whitelock St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Colored

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6-DATE OF BIRTH (month, day and year) unknown

7-AGE 62 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Distance

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Margaret Bowden

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Margaret Taylor

(Address) 1408 Whitelock St.

15- Filed APR 4 - 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 2-28-30

17- I HEREBY CERTIFY, That I attended deceased from 2-8-30, 19.., to 2-28, 19 30

that I last saw alive on 2-27, 19 30

and that death occurred, on the date stated above, at 11 45 p. m.

The CAUSE OF DEATH* was as follows:

Cystic Vaginitis — Renal Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. B. Butler M. D.

19 (Address) 1527 N. Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL, 2-4, 1930

20-UNDERTAKER John H Toadvine

ADDRESS 1027 Hanover

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54650 HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ E 54650

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 15-66

CITY OF BALTIMORE: (No. 1604 Moreland Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Andreas Deatel,

(a) RESIDENCE NO. 1604 Moreland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E.Deatel,

6 DATE OF BIRTH (month, day, and year) July 29.1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	27	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimpre Md.

PARENTS

10 NAME OF FATHER Charles A.Deatel,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Lydia L.Haupt,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Margaret E.Deatel

(Address) 1604 Moreland Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Mch 2, 1930, that I last saw h...alive on Mch 2, 1930 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Tubular Nephritis

(duration) Influenza yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine & Symptoms

(Signed) Deatel & Co, M. D.

3/3, 1930 (Address) 54 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL MAR 5 1930

20 UNDERTAKER Geo M Little

ADDRESS 2700 EDMONDSON AVE.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 54651

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54651

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2904 Poplar Terrace ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgia E. Roberts,

(a) RESIDENCE NO. 2904 Poplar Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 25, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Geo. W. Roberts.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lula A. Rosser,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs Sylvania Roberts (Address) 2904 Poplar Terrace

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1930, to March 3, 1930, that I last saw h-e- alive on March 3, 1930 and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis (Cancer)

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis myocarditis

(duration) 4 yrs — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) J. H. Linton, M. D.

3/3, 1930 (Address) 207 Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Woodlawn

DATE OF BURIAL MAR 5 1930

20 UNDERTAKER Geo. W. Little

ADDRESS 900 EDMONDSON AVE.

important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

Anna J. Finn

E 54652

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

E 54652

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3316 Woodland Ave ST., 21st WARD)

2—FULL NAME Anna F. Finn

(a) RESIDENCE NO. 3316 Woodland Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael V. Finn

6 DATE OF BIRTH (month, day, and year) Feb. 22 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	75		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Coy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Jerome J. Dixon

(Address) 3316 Woodland Ave.

15 Filed MAR 4 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929 to March 2, 1930

that I last saw h/w alive on March 2, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J. Gilbert M. D.

(Address) 758 Cath. Hospital Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae	March 5 1930

20 UNDERTAKER J. A. Hearn ADDRESS 300 E. Balto.

IF DEATH IS FROM VIOLENCE, so that it may be properly classified, state whether Accidental, Suicidal or Homicidal. Write plainly with ink. Use no abbreviations. Punctuation is important. See instructions on back of certificates.

Cor.—10-16-29—A Co.—100 Bks.

54653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-001 E 54653

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pennsylvania R.R. train enroute 12-19

City of Baltimore: (No. Washington to Baltimore. St.) (Ward)

2-FULL NAME Henry N. Johnson.

(a) RESIDENCE NO. Milford, Conn. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman, 66
(b) General nature of industry, business, or establishment in which employed (or employer) T. G. Hawkes Glass Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Long Island, N.Y.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Penrose Hawkes.
(Address) Corning, N.Y.

15 Filed 19 R.J.K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ulceration of Stomach
~~Carcinoma Pectoris.~~
Acute dilatation of the Heart
Otto M. Reinhardt M.D.
(duration) yrs. mos. ds. Coroner

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

3/8, 1930 (Address) 1019 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York - N.Y. DATE OF BURIAL March 19 30

20 UNDERTAKER E. Stewart Marvel ADDRESS Balto

MARA - 1-30

Use ink. Be careful, complete. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54654

CERTIFICATE OF DEATH

129 ✓ E 54654

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 78-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Malone (Sister M. Magdalene)

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 1 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): March 25. 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious

(b) General nature of industry, business, or establishment in which employed (or employer): Sister of Charity

(c) Name of employer: Nun

9 BIRTHPLACE (city or town) (State or country): Unknown Ireland

PARENTS

10 NAME OF FATHER: John Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Ireland

12 MAIDEN NAME OF MOTHER: Rosana Bannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Ireland

14 Informant: Mt Hope Nuns

(Address): Mt Hope Retreat

Filed APR 4 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 2. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1926, to March 2, 1930, that I last saw h[illegible] alive on March 2, 1930 and that death occurred, on the date stated above, at 6.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Senility)

Unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) Milton P. Hill, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Hope Cemetery	Mar 5/30
20 UNDERTAKER	ADDRESS
Stewart & Weaver Company	408-10 North Ave.

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54655

CERTIFICATE OF DEATH.

100-001

E 54655

REGISTERED NO. 15-602

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3703 Barrington Rd (St.) (Ward) 15

2-FULL NAME Minnie F. Stahm

(a) RESIDENCE No. 3703 Barrington Road (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John H Stahm

6 DATE OF BIRTH (month, day, and year) Oct 9-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
6	63	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Wm Woolgram

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John H Stahm

(Address) 3703 Barrington Rd

15 Filed MAR 4 - 1930 H. HANSELMAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2-1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1929, to March 2, 1930, that I last saw her alive on March 2, 1930, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

hypocarditis - chronic

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 2 yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General + Exam

(Signed) C. Holmes Boyd, M. D.

, 19 (Address) 104 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem DATE OF BURIAL Mar 4 30

20 UNDERTAKER H G Tuckwell & Co ADDRESS Catonsville

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54656

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54656

131

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 Riggs av ST. 16-68 WARD)

2-FULL NAME Mary Olivia Molly

(a) RESIDENCE NO. 2804 Riggs av ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L Molly

6 DATE OF BIRTH (month, day and year) Aug 4 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Baltimore md (State or country)

PARENTS

10 NAME OF FATHER Leonard Burbank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine

12 MAIDEN NAME OF MOTHER Mary Essender

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Henry L. Molly (Address) 2804 Riggs av

15 Filed MAR 4 - 1930 19 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 1930, to Mar 3rd 1930, that I last saw her alive on Mar 2nd 1930, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelo-Nephritis Chr

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis Clinical Laboratory findings

(Signed) W. Brauer M. D.

19 (Address) 101 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Mch 5 1930

20 UNDERTAKER John O Mitchell & Son — ADDRESS 1901 Eutaw Place

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54657

CERTIFICATE OF DEATH.

199 E 54657

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St. 3-4 Ward)

2-FULL NAME Jas. Chas Brooke

(a) RESIDENCE NO. 245 S. Caroline St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	Dont Know

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	Estimated		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lat. 040

(b) General nature of industry, business, or establishment in which employed (or employer) Junk Dealer

(c) Name of employer —

9 BIRTHPLACE (city or town) Dont Know

(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know

(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know

(State or country)

14 Informant Mercy Hosp

(Address)

15 Filed 1930, 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows: Crushed between moving auto truck and wall

Hom (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Tract Skull

(duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Francis M. D.

(Coroner)

3/3, 1930 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Return of 131 N East St

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Date of Burial 3/5/30

20 UNDERTAKER [illegible] ADDRESS 1735 Hoff St

MAR 4 1930

Don't write in this space. Age should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54658

CERTIFICATE OF DEATH.

31 E 54658

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) 1419 Darley Ave St. 8-45 (WARD)

2-FULL NAME Fred J. Conrad

(a) RESIDENCE NO. 1419 Darley Ave St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys M. Simson

6 DATE OF BIRTH (month, day, and year) Dec 15, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32 yrs	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer

(c) Name of employer White Bakery

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Fred Conrad

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Carrie C. Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Carrie C. Conrad

(Address) 1419 Darley Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr ....., 1928, to July 28, 1930,

that I last saw him alive on Feby 28, 1930,

and that death occurred, on the date stated above, at 1030 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Pulmonary Th.

(duration) 1½ yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 532 N. Bond St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) G. G. Thomathin, M. D.

3/3, 1930 (Address) 733 Argonne Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emanuel Lutheran Cemetery Forest Hill

DATE OF BURIAL Mar 3 1930

20 UNDERTAKER Edwin W. Conklin

ADDRESS 824 E. Eager St

MAR 4 1930 HAMPSON JONES, M. D.

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 54659 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54659

CERTIFICATE OF DEATH. 135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. 27-42 WARD

2-FULL NAME Wm Bohlman (Bohlman)

(a) RESIDENCE NO. 3905 Chesley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Estelle Bohlman

6 DATE OF BIRTH (month, day, and year): Nov. 1st 1865

7 AGE — Years: 64 — Months: 4 — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: State of Md.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Estelle Bohlman

(Address) 3905 Chesley ave.

15 Filed MAR 4 - 1930 [illegible] JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/2/30 19

17 I HEREBY CERTIFY, That I attended deceased from 2/25/30, 19, to 3/2/30, 19,

that I last saw him alive on 3/2/30, 19,

and that death occurred, on the date stated above, at 7 P M.

The CAUSE OF DEATH was as follows:

Hypertrophied prostate

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) J. M. Woodruff, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Feb. 6 1930

20 UNDERTAKER: Frederick Lasselmo Sons — ADDRESS: Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54660

90 E 54660

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 635 E. 35th St., 9-47 Ward)

2-FULL NAME Mary Jarousek

(a) RESIDENCE NO. 635 E. 35th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Jarousek

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
about 75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Trontina

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Frank Jarousek (son)
(Address) 635 E. 35th St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insufficiency

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Hypertension-Arteriosclerosis (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History given

(Signed) [signature], M. D.

3/3/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Mar 5 1930
20 UNDERTAKER	ADDRESS
Frank Cvach & Son 1906	Ashland

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 54661

E 54661

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 818 N. Madeira St ST 7-12 WARD)

2—FULL NAME Joseph Soler

(a) RESIDENCE NO. 818 N. Madeira ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Soler

6 DATE OF BIRTH (month, day, and year) Jan 15, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	L	10 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Myslive
(State or country) Bohemia

PARENTS

10 NAME OF FATHER Vojtech Soler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Marie Kolar

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Frances Soler
(Address) 818 N. Madeira St.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930 to Mar 2, 1930
that I last saw him alive on Mar 2, 1930
and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

March 4, 1930 (Address) 800 N. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 5, 30
20 UNDERTAKER	ADDRESS
Frank Cvach & Son	1906 Ashland Ave

important. See instructions on back of certificates.

MAR 4 - 1930 HAMPSON JONES M.D.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54662 ✓ 90 E 54662

E 54662

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.)..... ST. 21-29 (WARD)

2-FULL NAME John H. Fritz

(a) RESIDENCE NO. ~~Unknown~~ 1116 Ridgely ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~life~~ 60 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Fritz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Handlook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed - 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3/30

17 I HEREBY CERTIFY, That I attended deceased from 9-4-26, 19..... to 3-3-30, 19.....

that I last saw him alive on 3-3-30, 19.....

and that death occurred, on the date stated above, at 6:55 A. m.

The CAUSE OF DEATH* was as follows:

1. Myocarditis, Chronic Acute

(duration) 2 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 2 yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren McLean M. D.

3-3, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem

DATE OF BURIAL Mar 5, 1930

20 UNDERTAKER Mr. Mrs. J. W. Teufel & Son

ADDRESS 801 W. Fayette

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 54663

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 W 28th St 12-51 WARD)

2—FULL NAME George Lehr

(a) RESIDENCE NO. 328 W 28th St ST., WARD
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J. Lehr

6 DATE OF BIRTH (month, day, and year) July 20 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Lehr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah J. Lehr
(Address) 328 W 28th St

15 Filed 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10 1930 to Mar 3 1930 that I last saw him alive on Mar 3 1930 and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
+ Chronic Bronchitis

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

Mar 3 1930 (Address) 846 W 36 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	March 7, 1930
20 UNDERTAKER	ADDRESS
Thurow Thelon	3615 Chestnut ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54664 144

CERTIFICATE OF DEATH

E 54664

1—PLACE OF DEATH South Balto. Gen. Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 25-11 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Robertson

(a) RESIDENCE NO. 4105 Grace Court ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Milton L. Robertson

6 DATE OF BIRTH (month, day, and year): Feb. 20. 1893

7 AGE — Years: 37 — Months: — Days: 11 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Enoch Mewshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): a.a.Co. Md

12 MAIDEN NAME OF MOTHER: Achsah Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): a.a.Co. Md.

14 Informant: Mrs. Mewshaw

(Address): 4105 grace Court

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-3-1930.

17 I HEREBY CERTIFY, That I attended deceased from 3-1 ..., 19 30, to 3-3 ..., 19 30, that I last saw h C R alive on 3-3 19 30 and that death occurred, on the date stated above, at 5 55 A. m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) mo. 6 mos. ds.

CONTRIBUTORY (Secondary) post partum hemorrhage 4 hours.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes no Date of 3-3-30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis T. Bellis, M. D.

, 19 (Address) 1213 Eutaw Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elder Hill Cem

DATE OF BURIAL: March 5 1930

20 UNDERTAKER: Margaret L. Flynn

ADDRESS: 1820 Light St

MAR 4 - 1930

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

2345-03 E 54665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 54665

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Watson

(a) RESIDENCE NO. 405 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ga. (State or country)

PARENTS

10 NAME OF FATHER Jo. Watson

11 BIRTHPLACE OF FATHER (city or town) Ga. (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Shelton

13 BIRTHPLACE OF MOTHER (city or town) Ga. (State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1930 C. RAYMOND JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to March 2, 1930, that I last saw him alive on March 2, 1930 and that death occurred, on the date stated above, at 2 01 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological Tests

(Signed) Alexander Gunter, M. D.

3-4, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pendleton Car	March 6 1930
20 UNDERTAKER	ADDRESS
Sam'l N. Chase & Son	1400 Mosher

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54666 31 ✓ E 54666

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 Edward St. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Hazelton Moore.

(a) RESIDENCE NO. 1226 Edward St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Moore.

6 DATE OF BIRTH (month, day, and year) Feb. 15th 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Fred Hazelton.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellenor Gibson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Clayton Jackson.

(Address) 1226 Edward St.

15 MAR 4 - 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 28-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to Feb 28, 1930.

that I last saw h... alive on Feb 28, 1930

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Acute Lacunar Phthis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo [illegible], M. D.

3-4, 1930 (Address) 505 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Asbury Cemt.

DATE OF BURIAL 3/4/30 19

20 UNDERTAKER Mark C. Elliott

ADDRESS 1725 Ashland Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 54667

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1633 Ellsworth St., 8-13 Ward)

2-FULL NAME Nelson Person

(a) RESIDENCE NO. 1633 Ellsworth St., Ward

(Usual place of abode) 12 (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Person

6 DATE OF BIRTH (month, day, and year) Mar 5/1892

7 AGE	Years	Months	Days 27	IF LESS than 1 day hrs. or min.
	37	11	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Longshoreman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Franklin, N.C.

PARENTS

10 NAME OF FATHER Nelson Person

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Pennie Langford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.C.

14 Informant Eddie Person (Bro)
(Address) 1638 1638 Ellsworth S

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure- Arteriosclerosis

Nephritis- (Leuetic)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hopkins Disp. Record

(Signed) [illegible], M. D.

3/4/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Franklinton N. C.

DATE OF BURIAL Mar 5 1930

UNDERTAKER Manda Knowles

ADDRESS 1765 Madison

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54668

CERTIFICATE OF DEATH.

+ 123 E 54668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard Kelly Hospital ST., WARD 20

2-FULL NAME Mrs Florence Gray

(a) RESIDENCE NO. Columbia Mo ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Jos Gray

6 DATE OF BIRTH (month, day, and year) [illegible] 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
74	73 years	3 mos	4 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Columbia (State or country) Mo.

PARENTS

10 NAME OF FATHER Jas. Rollins

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mary Heckman

13 BIRTHPLACE OF MOTHER (city or town) Columbia (State or country) Mo

14 Informant (Address) Mrs John Stephens Columbia Mo

15 Filed MAR 4 - 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1930 to March 4th 1930 that I last saw h[illegible] alive on March 4th 1930 and that death occurred, on the date stated above, at 8 30 a m.

The CAUSE OF DEATH* was as follows:

Common duct gall stone

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Obstructive Jaundice

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Columbia Mo

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hellcaire Heil M.D.

3-4 1930 (Address) 448 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbia Mo — DATE OF BURIAL March 4 1930

20 UNDERTAKER — ADDRESS Edw. H. Pladwell 42 W. 25th ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54669

CERTIFICATE OF DEATH

E 54669

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Marburg Apts St. 10-14 Ward)

2-FULL NAME Mary Wolf

(a) RESIDENCE NO. 1043 N. Central St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Apr 2 - 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	47	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Jacob Wolf
11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Lena Wolf
(Address) 7340 Pasadena Ave

15 Filed ..... 19 ..... Registrar

APR 4 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Mar 3 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Accidently fell out of Windows 6th floor
Fractured Skull
(duration) ..... yrs. .....

CONTRIBUTORY (secondary) Was carrying wash working into Kitchen 9th floor
(duration) ..... yrs. ..... mos.

18 Where was disease contracted if not at place of death? Marburg Apts
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physical Exam
(Signed) H. H. Gaul, M. D.
Mar 3 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL March 6 1930

20 UNDERTAKER Henry Hoen Sons, Inc. — ADDRESS 1301 E Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54670 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54670

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 3607 Hudson ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Bergman

(a) RESIDENCE NO. 3607 Hudson ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Geo. Bergman

6 DATE OF BIRTH (month, day, and year) Dec 20th 1866

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Tourtschabeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Betz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Holmes

(Address) 3607 Hudson Ave.

15 MAR - 1930 HAMPSON JONES

19 Undertaker

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/27/30, 19..., to 3/2, 19 30, that I last saw her alive on 3/1/30, 19..., and that death occurred, on the date stated above, at 7 40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Myocarditis 2

(duration) ... yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Garrett, M. D.

3/3 1930 (Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 5th 1930
20 UNDERTAKER Leby — Fuller Inc.	ADDRESS 703 S. Wolfe St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54671

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54671

CERTIFICATE OF DEATH

90

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 723 S. Rose St., 1-3 Ward)

2-FULL NAME Frances Mehring

(a) RESIDENCE NO. 723 S. Rose St., 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Mehring

6 DATE OF BIRTH (month, day, and year) Nov. 8th 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	2	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Christopher Aurbein

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Michael Mehring (Husband)
(Address) 723 S. Rose St

15 Filed _____, 19____. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

I. Mitral Stenosis

(duration) 1 yrs. mos. 1 da.

CONTRIBUTORY (Secondary) E. H. Austin

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. G. Hadley, M. D.

(Address) 43 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL March 6th 1930

20 UNDERTAKER Lilly + Zeiler Inc.

ADDRESS 403 S. Wolfe St

MAR 4 1930

Not should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54672

HEALTH DEPARTMENT—CITY OF BALTIMORE

66 ✓ E 54672

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 1713 Lancaster St. 2-d Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. (Jack) Ward

(a) RESIDENCE NO. 1713 Lancaster St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11th 1871

7 AGE Years	Months	Days 20	IF LESS than 1 day ..... hrs. or ..... min.
59		18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired & Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Newark N. J.
(State or country)

PARENTS

10 NAME OF FATHER Luke Ward

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Winifred ?

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant John L. Ward Son
(Address) 1713 Lancaster St.

15 Filed MAR 4 1930 HAMPSON JONES M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) — yrs. — mos. 1 da.

CONTRIBUTORY (Secondary) ?

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy

Signed) [illegible] M. D.

, 19 (Address) 376 Bray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Mch. 5 1930
20 UNDERTAKER Kelly & Zeiler & Co	ADDRESS 405 S. Mayo Ave

How should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54673

CERTIFICATE OF DEATH

90 E 54673

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 N. Vincent ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Savina Perkins

(a) RESIDENCE NO. 712 N. Vincent ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. + mos. + ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. Perkins

6 DATE OF BIRTH (month, day, and year) 1893,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Days work

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Sollers

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Tabb

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Pearl Brown
(Address) 1723 Pressbury

15 Filed 4 1930, CHAMPION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/30

17 I HEREBY CERTIFY, That I attended deceased from 1/1, 1930, to 3/3, 1930, that I last saw her alive on 3/2, 1930 and that death occurred, on the date stated above, at 11 a, m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dan Francis M. D.

3/4, 1930 (Address) 1111 Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Lion	March 5 1930

20 UNDERTAKER Joseph A Sisk ADDRESS 704 N Monroe St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54674

CERTIFICATE OF DEATH

74-001

E 54674

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 628 Portland St. 22-30 Ward)

2-FULL NAME Sarah E. Phipps

(a) RESIDENCE NO. 628 Portland St., Ward Galesville Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James M. Phipps

6 DATE OF BIRTH (month, day, and year) Aug. 15-1853

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	77	6	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Raymond Phipps
(Address) 628 Portland St.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Tilden, M. D.

3/4, 1930 (Address) 727 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkside M.E. Ch.

DATE OF BURIAL Mar 6 1930

20 UNDERTAKER H. A. Standaft

ADDRESS Glenville

Blue should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54675

CERTIFICATE OF DEATH

31 E 54675

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2015 E Monument ST. 7-9 WARD)

2—FULL NAME Catherine Mitchell Lucas

(a) RESIDENCE NO. 2015 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Catherine Crompton Lucas

6 DATE OF BIRTH (month, day, and year): Nov 2 1897

7 AGE: Years 32 | Months 3 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer): Mechanic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Herbert Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Valentina Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Lucas

(Address) 2015 Monument

15 Filed MAR 4 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 3-1930

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1927 to March 3, 1930, that I last saw h[illegible] alive on March 3, 1930 and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic

(Signed) Edward J Lord, M. D.

3/3 1930 (Address) 418 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Mar 6th 1930

20 UNDERTAKER: Leo G. Cook

ADDRESS: 1733 N Caroline Ave

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 54676

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54676

43

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4 S. Payson ST. 20-28 (WARD)

2-FULL NAME Frederick Doell

(a) RESIDENCE NO. 4. S. Payson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug-29-1870.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass-blower

(b) General nature of industry, business, or establishment in which employed (or employer) Bottles

(c) Name of employer Swindell Bros.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Doell

11 BIRTHPLACE OF FATHER (city or town) Marburg (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Meyer

13 BIRTHPLACE OF MOTHER (city or town) Marburg (State or country) Germany.

14 Informant Mrs Clara List

(Address) 4704 Harford Rd.

15 Filed 4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3- 1930

17 I HEREBY CERTIFY That I attended deceased from January 31-1930 to March 3-1930 that I last saw him alive on March 2-1930 and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mouth & tongue

(duration) 1 yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Riland, M. D.

3-3-1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount 3-5 1930 DATE OF BURIAL

UNDERTAKER George L. Ashman ADDRESS 2201 Eutaw Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54677 E 54677

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3910 Duvalave ST. (or WARD) 15 25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Cameron Gordon Hendrick

(a) RESIDENCE NO. 3910 Duval ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Nicholas Hendrick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Christiana Huber

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Miss Martha Hendrick
(Address) 3910 Duval Ave

15 1930 C. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Mr Hetter, 19 29, to Mar 3rd, 19 30,
that I last saw h[illegible] alive on Mar 2nd, 19 30
and that death occurred, on the date stated above, at 9.15 A m.
The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J R Boulton M. D.

3/3. 1930 (Address) 3910 Gleneoe Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mar 5 1930

20 UNDERTAKER George A Smith — ADDRESS 163 Holliday

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4-1930

Spec.—1-12-23—M&T—500 Blks.

(Baugher)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54678

CERTIFICATE OF DEATH.

129 E 54678

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Annapolis Rd ST. 25-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie V. Baugher

(a) RESIDENCE No 2224 Annapolis Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 18 1903

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
27	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Enamel worker

(b) General nature of industry, business, or establishment in which employed (or employer): Blower 086

(c) Name of employer: Enamel Novelty Co

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Will Baugher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Bamberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Lillie Remsburg
(Address) 2224 Annapolis Rd

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

R 4-1930

TION is very important See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to March 2 1930, that I last saw her alive on March 2, 1930, and that death occurred, on the date stated above, at 10 10 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Heart test

(Signed) Raymond Sellman, M. D.

March 4, 1930 (Address) 2708 Hollins Ferry Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	3/5/30
20 UNDERTAKER	ADDRESS
Bernard G Fink	734 Poplar Grove St

Cor.—10-10-29—A Co.—100 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54679

CERTIFICATE OF DEATH

REGISTERED NO. E 54679

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Agnes Hospital (St.) 23-31 (Ward)

2-FULL NAME Robert Lindsay

(a) RESIDENCE NO. 140 N. Astend St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 — 1899

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	9	9 11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town)
(State or country) Jefferson Co W Va

10 NAME OF FATHER Philip Lindsay

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Charlestown W. Va

12 MAIDEN NAME OF MOTHER Anne Custer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Charlestown W. Va

14 Informant Mrs [redacted] Prine
(Address) 1107 Lanvale St

15 Filed 19 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Peritonitis from
Ruptured Appendix
(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. 2½ ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 3/1/30
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) Chas O Brook, M. D.
3/2, 1930 (Address) 3601 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hancock Md — DATE OF BURIAL 3/5 1930

20 UNDERTAKER Jack Lewis 1439 Eastern Ave — ADDRESS

R 5-1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO important. See instructions on back of certificate.

Cor.—10-10-20—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54680 E. 54680 100-001 54680

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1025 Ashland Ave St. (Ward) 10-14

2-FULL NAME Mary A. Henning

(a) RESIDENCE NO. 1025 Ashland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leroy Henning

6 DATE OF BIRTH (month, day, and year): Dec 24/1858

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	71	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Charwoman
(b) General nature of industry, business, or establishment in which employed (or employer): Balto. City Hall
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Arthur Murray

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Hagerty

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Ireland

14 Informant: Wm Hughes (nephew)
(Address): 2093 St. Benedict St

15 Mar 4 1930, 19... [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 1/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Failure

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary): Possible Bronchopneumonia

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? I found dead in her

(Signed) [signature], M. D.

3/1/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mar 6 1930
20 UNDERTAKER: Geo Schulting & Sons	ADDRESS: 1126 E Monument

Not enough or carelessly supplied. Also should be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate. OF DEATH in plain terms, so that it may be

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54681

E 54681

CERTIFICATE OF DEATH

REGISTERED NO. 92

1—PLACE OF DEATH: Union Memorial Hospital

CITY OF BALTIMORE: (No.) 33rd & Calvert ST., 7-H WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: Francis T. Homer. (HOMER)

(a) RESIDENCE NO. Ridenwood Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Mrs Francis D. Homer

6 DATE OF BIRTH (month, day, and year): Jan 6. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: Charles C. Homer.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Jennie C. Hollenbeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Hospital Records

(Address):

15 Filed 4-1930, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 3, 1930

that I last saw him alive on March 3, 1930

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ridenwood Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical course

(Signed) Francis N. Black, M. D.

3/3, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: 3/4 1930

UNDERTAKER: Thomson & Son

ADDRESS: 10 S. Calvert St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

(Shoolbred)

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 V

E 54682

E 54682

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 Allendale Rd 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Shoolbred

(a) RESIDENCE NO. 2405 Allendale ST. Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
M	W.	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Catherine F. Shoolbred

6 DATE OF BIRTH (month, day, and year) Oct 8-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	72	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman Retired 066

(b) General nature of industry, business, or establishment in which employed (or employer) Wood Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) Scotland

(State or country)

PARENTS

10 NAME OF FATHER James Shoolbred

11 BIRTHPLACE OF FATHER (city or town) Scotland

(State or country)

12 MAIDEN NAME OF MOTHER Mary Shoolbred

13 BIRTHPLACE OF MOTHER (city or town) Scotland

(State or country)

14 Informant Mrs Catherine Shoolbred

(Address) 2405 Allendale Road

15 Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1930, to March 4, 1930

that I last saw h.. alive on March 3 1930

and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ...yrs. ...mos. 5 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) ...yrs. ...mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typhoid

(Signed) W. S. Dublett M. D.

3/4/30 (Address) 2220 Fairview Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery DATE OF BURIAL Mar 5th 1930

20 UNDERTAKER Kirkland Lore ADDRESS 1723 W. Lafayette Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 54683

CERTIFICATE OF DEATH

E 54683

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Wicklow Road ST., 16-66 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A. Remmert

(a) RESIDENCE NO. 628 Wicklow Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 11 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
M	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Remmert.

6 DATE OF BIRTH (month, day, and year) Mar 9th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary Treasurer

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery 086

(c) Name of employer H. M. Wagner & Sons

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Remmert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hanna Schueda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary C. Remmert (Address) 628 Wicklow Road

15 Filed ..., 19 ... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to March 14th 1930, that I last saw h... alive on March 14 1930, and that death occurred, on the date stated above, at 2 45 m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

Myocarditis

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Oedema of Lungs, Chronic Endocarditis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination of Physician

(Signed) Joseph C. Jackson, M. D.

Mar 15 1930 (Address) 3201 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Mar 16th 1930

20 UNDERTAKER Peter Gore — ADDRESS 1723 W. Lafayette Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54684

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2303 Garrison Ave. ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gottfried Niederhauser

(a) RESIDENCE NO. 2303 Garrison Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Anna Sury Niederhauser

6 DATE OF BIRTH (month, day, and year) March 2, 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Niederhauser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Miss Rose Niederhauser

(Address) 2303 Garrison Ave.

15 Filed 4 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1930.

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1930, to March 2, 1930, that I last saw him alive on March 2, 1930 and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelo-cystitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Macke, M. D.

3/3/30 (Address) 932 N. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL March 5/30

20 UNDERTAKER Harry N. Britzke, 4101

ADDRESS Edmondson Ave.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 54685

E 54685

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3601 Belair Road St. 10-14 Ward)

2-FULL NAME Sarah M. Fonte

(a) RESIDENCE NO. 1022 Greenmount Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincent Fonte

6 DATE OF BIRTH (month, day, and year) Nov 8/1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48	3	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Magroni

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Samuel J. Fonte (son)
(Address) 1022 GreenmountAve

Filed 4-1930 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Hypertension

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr. ~~Levinson~~ report

(Signed) [signature], M. D.

3/4/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 3/6/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-30—M. & T.—250 Bks.

✓ Settle
2 of 35 Ind Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54686

E 54686

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2500 Maryland St. 42-51 WARD

2-FULL NAME Winfield M Nicholson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2500 Maryland ST., WARD

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna

6 DATE OF BIRTH (month, day, and year) June 30 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Grocerien 066

(c) Name of employer Wholesale Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Gould

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Fountain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Anna Nicholson

(Address) 2500 Maryland Ave

15 Filed APR 4 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1930

17 I HEREBY CERTIFY, That I attended deceased from March 2 19 30 to March 3 19 30,

that I last saw h living alive on March 3 19 30,

and that death occurred, on the date stated above, at 12.50 P m.

The CAUSE OF DEATH was as follows*: Pulmonalis

(duration) many yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo M Finley, M. D.

, 19 (Address) 1243 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 3/6/ 19 30

20 UNDERTAKER William Cook

ADDRESS 121 St Paul

ATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54687

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54687

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2—FULL NAME Charles Denkin

(a) RESIDENCE NO. 45 Wheeler Ave., Balto., Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 9 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Flake

6 DATE OF BIRTH (month, day, and year): May 7, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	68	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer 30

(b) General nature of industry, business, or establishment in which employed (or employer): Seaman

(c) Name of employer: SS Howard W. Jackson

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: William Denkin

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Catherine Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

R 4-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1930, to March 4, 1930, that I last saw h im alive on March 4, 1930, and that death occurred, on the date stated above, at 8:55 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

unknown
(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY
(Secondary)
(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? laboratory & clinical

(Signed) Ralph E. Porter, M. D.

3/4, 1930 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 3/6/1930

20 UNDERTAKER: J. M. Cook — ADDRESS: 1217 St. Paul St.

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

E 54688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

143-001 E 54688

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) St Agnes Hospital St. (or Ward) 12-50

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Regine Ryan

(a) RESIDENCE NO. 2205 St Charles St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm M. Ryan

6 DATE OF BIRTH (month, day, and year) March 26 - 1908

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	21	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER James M. Harrison

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna M. Grimes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant William H. Ryan

(Address) 2205 St. Charles St

15 Filed ..... 19 ..... Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1930

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Pelvic Peritonitis following abortion self produced

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Chas. F. Brooke M. D.

(Coroner)

, 19 (Address) 3601 - 3-5 Broadway Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

Date of Burial 3/5/1930

20 UNDERTAKER William Cole

ADDRESS 1217 St Paul Street

Of DEATH is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Dr Forsythe
✓ E North Ave

E 54689 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 E 54689

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4518 Schenley St. 22-53 WARD

2-FULL NAME Roy P. Grunewald

(a) RESIDENCE NO. 4518 Schenley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louise E

6 DATE OF BIRTH (month, day, and year) Feb 9/1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Investigator 03

(b) General nature of industry, business, or establishment in which employed (or employer) B. O.

(c) Name of employer Railroad Co

9 BIRTHPLACE (City or town) Balto
(State or country) Ind

PARENTS

10 NAME OF FATHER Frederick Grunewald

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Amelia E. Davis

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Louise E Grunewald
(Address) 4518 Schenley Road

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

R 4-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to Mch 3, 1930,
that I last saw him alive on Mch 3, 1930,
and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Spleen

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of May 29, 1929

Was there an autopsy? .....

What test confirmed diagnosis? Laboratory

(Signed) Hugh Forsythe, M. D.

3/4, 1930 (Address) 424 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 3/6 1930

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

SEE INSTRUCTIONS on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Dr Walter
3005 W. North Ave
Bal 0318

E 54690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-00 E 54690

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Darley Ave 8-45 WARD)

2-FULL NAME Nellie E. Markland

(a) RESIDENCE No. 1721 Darley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Clarence W.

6 DATE OF BIRTH (month, day, and year) Dec 9th 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	47	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) " " 037

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lena Claridge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimor Md

14 Informant Clarence N. Markland

(Address) 1721 Darley Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 2 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1930 to Mch 1 1930

that I last saw h[illegible] alive on Mch 1 1930

and that death occurred, on the date stated above, at 10.35 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal influenza

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas W. Calvert, M. D.

3/3, 1930 Address 3005 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimor Cemtery

DATE OF BURIAL 3/5 1930

20 UNDERTAKER Williams Cook

ADDRESS 1217 St. Paul

TION is very important. See instructions on back of certificates.

MAR 4 1930

Spec.—1-30—M. & T.—250 Blks.

E 54691 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54691

90

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals 72-30 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD

2-FULL NAME Amelia Reichel

(a) RESIDENCE NO. 523 S. Fremont Ave. ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3-30

17 I HEREBY CERTIFY, That I attended deceased from 8-11-23, 19 to 3-3-30, 19

that I last saw h... alive on 3-3-30, 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Fatal

(duration) over 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension: Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Herman W. McLean, M. D.

3-3, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL March 6 1930

UNDERTAKER Kendall J. Hoppel

ADDRESS 3004 Eden

TION is very important See instructions on back of certificates.

R

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54692 ✓

E 54692

CERTIFICATE OF DEATH. X 45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 25-27 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bruce Bosley

(a) RESIDENCE NO. 106 Buffalo St ST., Mannington W. Va WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ollie Bosley

6 DATE OF BIRTH (month, day, and year): ? 1876

7 AGE: Years 54 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Beverly W. Va

PARENTS

10 NAME OF FATHER: William

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Mary Haron

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant (Address): Mrs Ollie Bosley 106 Buffalo St

15 Filed MAR 5 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-4 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-20 1930 to 3-4 1930

that I last saw him alive on 3-4 1930,

and that death occurred, on the date stated above, at 3.55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma (adeno) Rectum

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Operation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-1-29

Was there an autopsy? No

What test confirmed diagnosis? Operation, Clinical Studies

(Signed) Nicholas J. Bonelli, M. D.

3/4. 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mannington W. Va

DATE OF BURIAL: 3/5 1930

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun Hollow

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54693

CERTIFICATE OF DEATH

97-002 ✓

E 54693

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Mem. Hos. WARD 12-19)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Wyman

(a) RESIDENCE NO. 3627 Greenmount Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion Wyman

6 DATE OF BIRTH (month, day, and year) 6-19-1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Drafting

(c) Name of employer Western Elec. Co.

9 BIRTHPLACE (city or town) (State or country) Michigan.

PARENTS

10 NAME OF FATHER William Wyman.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Michigan.

12 MAIDEN NAME OF MOTHER Minnie McKee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan.

14 Informant Mrs. Arthur Wyman.

(Address) 3627 Greenmount Ave.

15 Filed APR 5 - 1930, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to March 3, 1930

that I last saw h[illegible] alive on March 3, 1930

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Splenomedal Leukemia

Dr. Coroner Notified,

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 3627 Greenmount Ave.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) A. E. Wilkerson, M. D.

, 19 (Address) Univ Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fort Lyn[illegible] Cemetery - Md.

DATE OF BURIAL May 5 1930

20 UNDERTAKER Stewart Memorials

ADDRESS Balto

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54694 ✓ E 54694

CERTIFICATE OF DEATH

90

E 54694

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1770 Montpelier ST., 9-46 WARD)

2—FULL NAME Sarah Daugherty

(a) RESIDENCE NO. 1770 Montpelier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Dougherty

6 DATE OF BIRTH (month, day, and year) Sept - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) ditto

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John McConnick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Moray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jennie Snyder

(Address) 1770 Montpelier

15 Filed MAR 5 1930, 19 RLH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1927, to March 1, 1930, that I last saw her alive on March 1, 1930 and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

3/3 (Signed) Y V Kinsey, M. D.

(Address) 2700 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	March 1930
20 UNDERTAKER	ADDRESS
Fred A. Wenzel	753 Hanover St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

54695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 ✓

E 54695
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) Providence Hosp. St. 14-20 (Ward)

2-FULL NAME Nellie Mae William Van Hearst

(a) RESIDENCE NO. 1527 Druid Hill Ave., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: Col
5 Single, Married, Widowed or Divorced, (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE: 25 Years; Months; Days; IF LESS than 1 day ... hrs. or ... min.
24

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Paul McWilliam

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Flora Hyden

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant: Flora McWilliam
(Address) 1527 Druid Hill

15 Filed ... 1930 ... Registrar

MAR 5 - 1930 HA... Commissioner of M...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) ... M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery
DATE OF BURIAL: May 5, 1930

20 UNDERTAKER: Mrs. Katie R Williams
ADDRESS 222 N. Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary
important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 E 54696

REGISTERED NO. E 54696

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4005 Wilsby Ave ST., 9-47 WARD)

2-FULL NAME Sarah Cordelia Nuquent

(a) RESIDENCE NO. 4005 Wilsby ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Timothy Joseph Nuquent Divorced

6 DATE OF BIRTH (month, day, and year) May 8 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77 78	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ironton, Ohio.

PARENTS

10 NAME OF FATHER Jacob Fauble

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Elizabeth Roch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Mrs. Anna F. Williamson (Address) 4005 Wilsby Ave.

15 Filed ..., 19... Registrar

MAR 5 - 1930 CHAMBERS, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1930, to March 1, 1930, that I last saw h.er alive on March 1, 1930 and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Art. Sclerosis

Senility

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis Ellis, M. D.

, 19 (Address) 616 Dumbarton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Council Bluffs, Iowa

DATE OF BURIAL Mar 5, 1930

20 UNDERTAKER J. A. Horan

ADDRESS 3000 E. Balto. St.

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54697 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 54697

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 16-23 ST. (WARD)

2-FULL NAME George Slater

(a) RESIDENCE NO. 1014 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardener

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed MAR 5 - 1930 HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27-30

17 I HEREBY CERTIFY, That I attended deceased from 4-1-29, 19..., to 2-27-30, 19...,

that I last saw him alive on 2-27-30, 19...,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Diffuse

(duration) over yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) over yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McClain, M. D.

2-27, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 3/5 1930

UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Eastern Ave

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Kowtsoudakis ✓ 100-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54698 E 54698

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO. 36-37

CITY OF BALTIMORE: (No. 6716 Graceland Ave ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Kowtsoudakis

(a) RESIDENCE NO. 6716 Graceland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Sept/15/1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Theodore Kowtsoudakis

11 BIRTHPLACE OF FATHER (city or town) Turkey
(State or country)

12 MAIDEN NAME OF MOTHER Edna Pelekakis

13 BIRTHPLACE OF MOTHER (city or town) Greece
(State or country)

14 Informant Theodore Kowtsoudakis
(Address) 6716 Graceland Ave

15 Filed 5-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4-30

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1920, to March 4, 1930

that I last saw h alive on March 4, 1930

and that death occurred, on the date stated above, at 1.36 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M.D.

(Address) 1 E 50 Broadway

March 4-30

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL March 6 1930

20 UNDERTAKER George A Weber 706 Lanvale — ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 ✓ 15

REGISTERED NO. E 54699

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Balto. Gen ST. [illegible] WARD)

2—FULL NAME James Melvin Evans

(a) RESIDENCE NO. 1147 Monroe Circle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 5 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 8, 1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
9 yrs	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Thomas Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sola Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant mother

(Address) 1147 Monroe Circle

15 Filed 5-1930 19 HAMPTON JONES, M. D. Registrar By RLH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to March 4, 1930, that I last saw him alive on ~~Feb~~ March 4, 1930 and that death occurred, on the date stated above, at 1:13 a. m.

The CAUSE OF DEATH* was as follows:

Perforated appendicitis

& Peritonitis

5 days (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) [redacted] Paralytic Ileus

Embolism (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 3/24/30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) E. A. Lehmann, M. D.

, 19 (Address) 1213 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bidg. Hill Bem	Mar 7 1930
20 UNDERTAKER	ADDRESS
H. Brand Evans	30 E Eutaw

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Mc Kim

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54700

E 54700

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Druid Hill St. 4th WARD)

2-FULL NAME Robert Mc Kim

(a) RESIDENCE NO. 1125 Druid Hill Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) 1869 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Or

(c) Name of employer

9 BIRTHPLACE (city or town) Groundown Md
(State or country)

PARENTS

10 NAME OF FATHER John McKim

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Chase

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Md.

14 Informant Sarah McKim
(Address) 2522 Druid Hill Ave

15 Filed MAY 5 - 1930 C. HA[illegible] KIES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 28 1930 to March 3 1930,

that I last saw h[illegible] alive on March 2 1930,

and that death occurred, on the date stated above, at 12.50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

3/3. 1930 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 3/6 1930

20 UNDERTAKER Samuel V. Stansbury

ADDRESS 578 W Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24 001 E 54701

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 364 W. Biddle (St.) 11-24 (Ward)

2-FULL NAME John Weston

(a) RESIDENCE NO. 364 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Galesville Md

PARENTS

10 NAME OF FATHER John Weston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lucy W. Campbell (Address) 207 Md. Av. City

15 Filed MAR 5 - 1930 19 Ellis Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4/30

17

I HEREBY CERTIFY, That I attended deceased from Mar 2 1930, to Mar 4 1930,

that I last saw him alive on Mar 4 1930,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Cotterman, M. D.

19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 3/6 1930

UNDERTAKER Samuel L. Handley

ADDRESS 1 N Bdle

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54702 100-001 E 54702

CERTIFICATE OF DEATH

E 54702

1—PLACE OF DEATH House for Incurables REGISTERED NO. 15-58

CITY OF BALTIMORE: (No. 40th St. Keswick Rd. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine C. Bructow

(a) RESIDENCE NO. 3437 Park Heights Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 0 mos. 17 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Noble F. Bructow

6 DATE OF BIRTH (month, day, and year) Feb. 15 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	0	19	19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gen old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER George F. Sahm

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Margarite Harman

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs Dora Margaret Good

(Address) 3437 Park Heights Ave

15 Filed (Date) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1930, to March 4, 1930, that I last saw her alive on March 3, 1930 and that death occurred, on the date stated above, at 7.20 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia following a head cold of 10 days duration

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) pulmonary edema (duration) yrs. mos. 48 hrs. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical examination

(Signed) H. S. Willis, M. D.

, 19 (Address) Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem DATE OF BURIAL May 5 1930

20 UNDERTAKER Wm J Gickner Sons ADDRESS N. Y. Pa

Important. See instructions on back of certificates.

MAY 5-1930 C. H. [illegible]

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54703 — 31 — E 54703

1—PLACE OF DEATH Baltimore City Hospitals (Tbc. 12-5T) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Banks

(a) RESIDENCE NO. 2538 Mace st. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Banks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Listy Moody

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Records
(Address)

MAR 5 1930 C. H. Robbins M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1930, to March 2, 1930, that I last saw him alive on Marcy 2, 1930 and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas Grinnold M.D.

3-3-, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary cem.

DATE OF BURIAL Mar 5 1930

20 UNDERTAKER Mrs. P. A. Elliott

ADDRESS 1925 Ashland Ave

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54704

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 54704

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 Shuter ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eliza Taylor

(a) RESIDENCE NO. 617 Shuter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Taylor

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64 63				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. D

PARENTS

10 NAME OF FATHER John Crockett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. D

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant William Taylor

(Address) 617 Shuter St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2/30.

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 19 30, to March 2, 19 30, that I last saw her alive on March 1, 19 30, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast Exhaustion

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & Symptoms

(Signed) Charles A. Wallace M. D.

(Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	march 5 1930
20 UNDERTAKER Edward Bryan	ADDRESS 1631 orleans st.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54705

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54705

CERTIFICATE OF DEATH

101-09

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. 1836 E. Eager ST., 7-13 WARD)

2—FULL NAME Edward Johnson

(a) RESIDENCE NO. 1836 E. Eager ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) apr. 16-1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur 023
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Columbus Johnson
11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)
12 MAIDEN NAME OF MOTHER Hettie Hilliard
13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hettie Johnson Compton
(Address) 1836 E. Eager St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1930, to Mar. 3, 1930, that I last saw h— alive on Mar. 3, 1930 and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. diagn.

(Signed) William O'Leary, M. D.

19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Cemetery	Mar. 7 1930
UNDERTAKER Chas. H. Johnson 466 N.	ADDRESS Gaylord Sts.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 54706

REGISTERED NO. 46-42

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4304 Spaulding ST., W. Ward 42

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. Murphy.

(a) RESIDENCE NO. 4304 Spaulding ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 2 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19th 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	2	11	13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired machinist.

(b) General nature of indastry, business, or establishment in which employed (or employer) 21

(c) Name of employer B & O R R.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Patrick Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget.

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Rose E. Bell.

(Address) 4304 Spaulding Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 27 1930, to March 2, 1930,

that I last saw h alive on March 1 1930

and that death occurred, on the date stated above, at 7.30 P.m.,

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

Acute Dilatation of Heart.

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis.

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert G Webster, M. D.

March 3, 1930 (Address) 6409 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 3/6/1930

20 UNDERTAKER John J Cowan & Son.

ADDRESS 300 Gallows

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54707

CERTIFICATE OF DEATH.

90 E 54707

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. St. Agnes Hospital ST. WARD)

2-FULL NAME Mrs Mabel Lee

(a) RESIDENCE NO. 3023 E. Baltimore St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lindon

6 DATE OF BIRTH (month, day, and year) Oct 22. 1881

7 AGE 48 Years 49 Months 4 Days 7/8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Martin Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) NC

12 MAIDEN NAME OF MOTHER Mary Trotlyford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) NC

14 Informant Mrs Gregory (Address) 808 Linden Ave

15 Filed MAR 5 - 1930 G. HAMPSON JENKINS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-21, 1930, to 3-4, 1930, that I last saw h[illegible] alive on 3-4, 1930, and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cleon Greene, M. D.

(Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 3/6/30

20 UNDERTAKER John Ullrich

ADDRESS 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54708

CERTIFICATE OF DEATH

91-602

E 54708

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 720 N Bond St. 3-4 Ward)

2-FULL NAME Albert A Kamke

(a) RESIDENCE NO. 720 N Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernestine Kamke

6 DATE OF BIRTH (month, day, and year) Apl 4 - 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	79	10	2018	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Caretaker
(b) General nature of industry, business, or establishment in which employed (or employer) Balto City Parks
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Leopold Kamke

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Caroline Harrison
(Address) 515 S Lakewood Ave

Filed MAR 5 - 1930 Wm. Jay Jones M D Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What was confirmed diagnosis? Exhaustion

(Signed) Geo E Blacke M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem

DATE OF BURIAL 3/6/1930

20 UNDERTAKER John Welsch

ADDRESS 2008 Aliceanna St

Do not write in this space. All items should be carefully supplied. Any item that cannot be stated EXACTLY, should be stated APPROXIMATELY. Information given on this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 54709

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54709

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 16-31 ST., WARD)

2-FULL NAME Sophia ~~Roemer~~ Roemer,

(a) RESIDENCE NO. 1102 Baylis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oswald Roemer

6 DATE OF BIRTH (month, day, and year) February 4th 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1 11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Europe Germany

PARENTS

10 NAME OF FATHER Herman Howschild

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe Germany

12 MAIDEN NAME OF MOTHER Louise ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe Germany

14 Informant Records of (Address) Balto. City Hospitals

15 Filed MAR 5 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4-30

17 I HEREBY CERTIFY, That I attended deceased from 3-1-30, 19, to 3-4-30, 19, that I last saw her alive on 3-4-30, 19, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Obesity

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harris McC. McLean, M. D.

3-4, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cem

DATE OF BURIAL 3/7/30

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54710 ✓ 31 E 54710

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Lakes Shirs + Callow Ave (ST.) 13-59 (WARD)

2-FULL NAME Ross Brotherman

(a) RESIDENCE NO. Lakes Shirs + Callow Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hyman Brotherman

6 DATE OF BIRTH (month, day, and year) March 11-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34	11	22 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Bala, Md.

PARENTS

10 NAME OF FATHER Barnett Ellis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lizzie Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hyman Brotherman Husband
(Address) Lakes Apts. C1

15 APR 6-1930 H. W. Kelly Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16th, 1927, to March 6th, 1930, that I last saw h[illegible] alive on March 5th, 1930, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 7 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. 1 da.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms, history, examination

(Signed) Chas C. Hebbeler, M. D.

3/5, 1930 (Address) 104 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 3-5-1930

20 UNDERTAKER Jack Lewis, 1439 E Balto St — ADDRESS

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54711
1-PLACE OF DEATH

90 ✓ E 54711
REGISTERED NO.

30-71

City of BALTIMORE: (No. 404 Lyndhurst St St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas C. Murray

(a) RESIDENCE NO. 404 Lyndhurst St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11, 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	56	(	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jesse H Murray

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Tracey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Mary E Murray

(Address) 404 Lyndhurst St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 19 25, to Mar 3rd, 19 30,

that I last saw him alive on Mar 3rd, 19 30,

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death:

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) A. L. L. Lucas, M. D.

3/4, 1930 (Address) 3421 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mount Olivet	March 6 1930
20 UNDERTAKER	ADDRESS 1572
F Vernon Kechner	Holins St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 1116.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 54712 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54712

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Roslyn Ave St.) 15-L1 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Clara Hellen

(a) RESIDENCE. No. 2202 Roslyn Ave St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug-14-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Columbus Stuart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Ellen Poole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

11 Informant Myron Hellen

(Address) 2202 Roslyn Ave

15 Filed MAR 5 - 1930 19 Registrar RLK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby-20 1930, to Mar-4 1930, that I last saw h alive on Mar 4 1930, and that death occurred, on the date stated above, at 11-15 a.m.

The CAUSE OF DEATH was as follows:

Acute Lobar Pneumonia Rt Lower.

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wesley Cole, M. D.

3/4, 1930 (Address) 2202 Roslyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 6 1930
20 UNDERTAKER George Smith	ADDRESS 1532 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 54713

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 West North ave ST. 13-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Conrad Eckhardt

(a) RESIDENCE NO. 834 West North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 2nd 1876

7 AGE: Years 53 Months 5 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cutter Binder

(b) General nature of Industry, business, or establishment in which employed (or employer): 045

(c) Name of employer: dep Baltimore Md

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis Eckhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Katz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William Eckhardt

(Address) 834 West North ave

15 Filed MAR 5 - 1930 H. [illegible] JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1929, to March 3, 1930,

that I last saw him alive on March 3, 1930

and that death occurred, on the date stated above, at 12:05 a m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

Aortic insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism and stroke

chronic nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? place of living and home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) C Hamm, M. D.

, 19 (Address) 1215 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 3/6/1930

20 UNDERTAKER: Jos. Sutton & Son — ADDRESS: 2503 Edmondson

IMPORTANT. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 54714

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54714

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 16-37 Ward)

2-FULL NAME Richard Sands

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? 2 yrs. 2 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
59		2.	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer Backover

9 BIRTHPLACE (city or town)

(State or country) Paris

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) France

14 Informant Mrs Marie Elder

(Address) 2432 Loretta Ave

15 Filed MAR 6 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

Signed: G. C. Glades M. D.

(Coroner)

19 (Address) 432 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — Date of Burial 3/6/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

FOR INFORMATION ONLY. NOT A PERMIT FOR BURIAL. Physicians are requested to write plainly, and to use no abbreviations. Give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54715

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54715

CERTIFICATE OF DEATH

38

1—PLACE OF DEATH Franklin Square Hospital

REGISTERED NO. 22-38

CITY OF BALTIMORE: (No. Fayette & Calhoun St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Clara Scardina

(a) RESIDENCE NO. 10 E York St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Salvadore Scardino

6 DATE OF BIRTH (month, day, and year) 4/11/1889

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
40	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 31

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Alfred High

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Salvadore Scardina

(Address) 10 E. York St

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1930, to March 4, 1930, that I last saw h[illegible] alive on March 4, 1930 and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Tertiary Syphilis

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann Test(s)

(Signed) D.B. Schneider, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 3/7 1930

20 UNDERTAKER Wm Cook

ADDRESS 1478 Park

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54716

CERTIFICATE OF DEATH

44 ✓

E 54716

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 E Fayette, ST.) 8-45 (WARD)

2—FULL NAME Conrad Schneider

(a) RESIDENCE NO. 1755 Oailey ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 7 mos. dis. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schneider

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital records
(Address)

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

5-T330

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/30

17 I HEREBY CERTIFY, That I attended deceased from 1/30/30, 19..., to 3/31/30, 19..., that I last saw him alive on 3/31/30, 19..., and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dyspnea

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 2/25/30

Was there an autopsy? No

What confirmed diagnosis? Clinical

(Signed) Thos A Dwyer M. D.

(Address) 1 E Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Baltimore Cemetery

DATE OF BURIAL
March 5 1930

20 UNDERTAKER
Geo. F. Rust

ADDRESS
1755 Harford ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54717 ✓ *90 E 54717.

CERTIFICATE OF DEATH

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 9-17 (Ward)

2-FULL NAME John Klones

(a) RESIDENCE NO. Stevens & Md. St., _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. / _____ ds. How long in U. S., If of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
about 45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Probably
(b) General nature of industry, business, or establishment in which employed (or employer): Coal Miner
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) "

14 Informant N. E. Police Record
(Address)

15 Filed MAR 5 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 19/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? (over)

(Signed) _____, M. D.

1/27/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS MAR 5 - 1930

411 THE MORGUE.

tion should be carefully supplied. AGE should be stated EXACTLY. If CHILDREN OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54718 46 E 54718

CERTIFICATE OF DEATH

REGISTERED NO. 1724

1—PLACE OF DEATH U.S. Marine Hospital Baltimore, Md.

CITY OF BALTIMORE: (No. ____ St. ____ WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Victoria Pendleton

(a) RESIDENCE NO. 536 Oxford St., Baltimore, Md. ST. ____ WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	58	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chambermaid 0 7 0

(b) General nature of industry, business, or establishment in which employed (or employer) Merchan Seawoman

(c) Name of employer SS City of Norfolk

9 BIRTHPLACE (city or town) Norfolk
(State or country) Virginia

PARENTS

10 NAME OF FATHER Nicholas Langley

11 BIRTHPLACE OF FATHER (city or town) Norfolk
(State or country) Va.

12 MAIDEN NAME OF MOTHER Adeline Mitchell

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) North Carolina

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Md.

15 Rec'd MAR 5 - 1930 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1929, to March 4, 1930,
that I last saw him alive on March 4, 1930
and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) unknown yrs. ____ mos. ____ da.

CONTRIBUTORY (Secondary) Recto vaginal fistula

(duration) 7 yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Clinical and laboratory

(Signed) W. P. Linden, M. D.

3/4/30 19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk - Va.

DATE OF BURIAL 3/6/30

20 UNDERTAKER Hendrix & H. Holland

ADDRESS 1611 Druid Hill

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 V

E 54719

CERTIFICATE OF DEATH

E 54719

REGISTERED NO. 22-31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 China ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Roland Joseph Johnson

(a) RESIDENCE NO. 839 China ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 4 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	—

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-30-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	2	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Elizabeth City

(State or country) N. Carolina

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) Salisbury

(State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Allie Riddick

13 BIRTHPLACE OF MOTHER (city or town) Belvidere

(State or country) N. Carolina

14 Informant William Johnson

(Address) 839 China

15 Filed 5-1930 C. H. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4/30

17 I HEREBY CERTIFY, That I attended deceased from 3/2, 1930, to 3/4, 1930, that I last saw him alive on 3/3, 1930 and that death occurred, on the date stated above, at 12:55 a. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? none

(Signed) Chas Frankenberg M. D.

3/4 1930 (Address) 1111 Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem

DATE OF BURIAL March 6 1930

20 UNDERTAKER D. J. & J. Brown's Son

ADDRESS 1128 W. Baltimore St

Important. See instructions on back of certificate.

Spec.—1-10 21—M&T—1500 Bks.

(Quinn)

E 54720

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1317 Mt Royal Ave ST. (WARD) 24

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L. Quinn

(a) RESIDENCE NO. 1317 Mt Royal ave ST. WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Quinn

6 DATE OF BIRTH (month, day and year): March 1847

7 AGE: Years 63 Months 0 Days 11
If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS
10 NAME OF FATHER: Wm Quinn
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary Quinn 1317 Mt Royal ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MAY 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/31/30

17 I HEREBY CERTIFY, That I attended deceased from 1/11 1930 to 3/31 1930
that I last saw h alive on 3/31 1930
and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Metastatic Sarcoma, Lung
Contributory Arteriosclerosis
Duration yrs 3 mos da

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) A. Lee Cole, M. D.
(Address) 1317 Mt Royal ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral
DATE OF BURIAL: Mar 6 1930

20 UNDERTAKER: John J Moran
ADDRESS: 3000 E Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54721

CERTIFICATE OF DEATH

16 V E 54721

1—PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) , ST. 27-56 WARD 6

2—FULL NAME Baby Keating

(a) RESIDENCE NO. 5102 (Usual place of abode) Litchfield Ave ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1930

7 AGE Years Months Days If LESS than 1 day 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 00

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Keating

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant R. G. Douglas

(Address) Johns Hopkins Hospital

15 Filed 5-1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-21, 1930 to 2-21, 1930

that I last saw him alive on 2-21, 1930

and that death occurred, on the date stated above, at 5.18 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) R. G. Douglas, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER D. Commissioner Health

ADDRESS MAR 5 - 1930

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54722 ✓ 38 E 54722

E 54722

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6-9 ST., WARD)

2—FULL NAME Baby Bailey

(a) RESIDENCE NO. 1645 E. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Black | 5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1930

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Raymond Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Boles

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant L. G. Douglas
(Address) Johns Hopkins Hospital

15 Filed ..... 19 .....
Per ..... Registrar

R 5-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-17, 1930, to 2-17, 1930

that I last saw him alive on 2-17, 1930

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. G. Douglas M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS MAR 5 - 1930

C. HAMPSON JONES, M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

23753 8 E 54723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 24 E 54723

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virginia Louise Fox

(a) RESIDENCE NO. Garrison-Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 30-1927

7 AGE: Years 2 Months 3 mos Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER Wm Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md —

12 MAIDEN NAME OF MOTHER Martha Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md —

14 Informant: Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 Registrar

MAR 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 3-30

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to Mar. 3, 1930, that I last saw her alive on Mar. 3, 1930 and that death occurred, on the date stated above, at 1 30 P. M.

The CAUSE OF DEATH* was as follows:

meningococcus meningitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes —

What test confirmed diagnosis?

(Signed) Benjamin E. Dodge M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health.

ADDRESS MAR 5 1930

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 ✓ E 54724

1—PLACE OF DEATH

Johns Hopkins Hospital.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1 E ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Evans

(a) RESIDENCE NO. Simonsville, ST. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 15 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1 1/2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: E. Irving Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Adelaide McClair

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: L. G. Douglas

(Address): 6

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-15, 1930, to 2-16, 1930, that I last saw her alive on 2-16, 1930 and that death occurred, on the date stated above, at 5.50 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. G. Douglas, M. D.

(Address) 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS

MAR 5 - 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54725

CERTIFICATE OF DEATH

129 E 54725

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 E. 30 St. ST., 9-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie L. Glenn

(a) RESIDENCE NO. 2012 E 30 St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Glenn

6 DATE OF BIRTH (month, day, and year) March 26 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	11	7 9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cork

(State or country) Ireland

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) Cork

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne Hannan

13 BIRTHPLACE OF MOTHER (city or town) Cork

(State or country) Ireland

14 Informant Mrs. Rose M. Mason

(Address) 2012 E. 30 St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MAY 5 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1930

17 I HEREBY CERTIFY, That I attended deceased from February 21, 1930, to Mch 5, 1930

that I last saw h-er alive on Mch 4, 1930

and that death occurred, on the date stated above, at 8 10 a m.

The CAUSE OF DEATH* was as follows:

Uremic Sclerosis 1 wk

Hypertension 1 wk

Cerebral Hemorrhage 3 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine & Symp.

(Signed) Thos Fa Stevens, M. D.

3/5, 1930 (Address) 2818 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 7 1930
20 UNDERTAKER Chas F. Evans & Son	ADDRESS Mount Royal Ave

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54726

CERTIFICATE OF DEATH.

1924 E 54726

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital

2-FULL NAME Stanley Colgan

(a) RESIDENCE NO. 514 Gatewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Colgan

6 DATE OF BIRTH (month, day, and year) Feb. 29, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer. do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Seaford Delaware.

PARENTS

10 NAME OF FATHER Stanley Colgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Mary L. Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Mrs. McComsey. (Address)

15 Filed 5-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-5 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-7, 1930, to 3-5, 1930, that I last saw him alive on 3-5, 1930, and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. Mc Mennamy, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Providence Cem

DATE OF BURIAL 2/8 1930

20 UNDERTAKER E. G. Kurtz & Son,

ADDRESS Jarrettsville Md

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54727

CERTIFICATE OF DEATH

90 E 54727

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2923 W Lanvale ST. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest A. Friers Sr.

(a) RESIDENCE NO. 2923 W Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if foreign birth 56 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Friers

6 DATE OF BIRTH (month, day, and year): Oct 19 1855

7 AGE: Years 74 | Months 4 | Days 12 15 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watch-Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Augusta Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Mary A. Friers

(Address) 2923 W Lanvale

15 Filed MAR 5 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Mar 4, 1930

that I last saw h... alive on Mar 3, 1930

and that death occurred, on the date stated above, at 5:10 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. Valvular Heart Disease (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

3/4. 1930 (Address) 1663 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: Woodlawn

DATE OF BURIAL: MAR 7 1930

20 UNDERTAKER: Geo W Settles

ADDRESS 2700 EDMONDSON AVE.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 54728 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54728

CERTIFICATE OF DEATH.

48

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST. 15-68 WARD)

2-FULL NAME Rachael Kreigel

(a) RESIDENCE NO. 2101 Baker ST. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Kreigel

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years 73 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Elfa Ginsburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address)

Filed 5-15 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1929, to March 5th 1930.

that I last saw h— alive on 3/5/30, 19...,

and that death occurred, on the date stated above, at 5.9 m.

The CAUSE OF DEATH* was as follows:

adeno-Carcinoma of scalp. with general metastasis

(duration) One yrs. 3 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Dec-1928

Was there an autopsy? no

What test confirmed diagnosis? Biopsy with pathologic exam

(Signed) Heyman Edwards M. D.

3/5 1930 (Address) 2404 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL German Hill North Comb DATE OF BURIAL 3/6/30

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54729

CERTIFICATE OF DEATH

31 E 54729

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD) 14-27

2—FULL NAME Althea Snelson

(a) RESIDENCE NO. 18 N. Calhoun st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress 0 10

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Charles Wofe

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Blanch Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Hospital Records
(Address)

15 Filed 5-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to March 5, 1930, that I last saw her alive on March 5, 1930 and that death occurred, on the date stated above, at 11.20 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Gibnol D

3-5, 19 30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkins W. Va. DATE OF BURIAL March 6 1930

20 UNDERTAKER John C. Miller 2435 E Oliver ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

E 54730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 54730

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2114 Bolton ST. 13-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Ellen Dorsey

(a) RESIDENCE NO. 2114 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 6 - 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
94	94	7 - 57	— 28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Carroll Co. Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Dorsey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Carroll Co Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Carroll Co Md

14 Informant Ellen P Smith
(Address) 702 Gladstone Ave

15 Filed ..., 19 ... Registrar

C. HAMPSON JONES, M. D.

MAR 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to March 4, 1930, that I last saw h[illegible] alive on Mar 4 - at 11 am 1930 and that death occurred, on the date stated above, at 7 P — m.

The CAUSE OF DEATH* was as follows:

Senility

Had grad[illegible] ill and [illegible]

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 19 (Address) 108 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

20 UNDERTAKER George J Smith

DATE OF BURIAL Mar 6 1930

ADDRESS 1934 Holbrook

important. See instructions on back of certificates.

Cor.—12-9-25—A Co—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54731

CERTIFICATE OF DEATH.

REGISTERED NO. E 54731

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1906 Longwood St. 15-67 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lenna A Willis

(a) RESIDENCE NO. 1906 Longwood St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: N. H. Willis

6 DATE OF BIRTH (month, day, and year): Oct 16. 1866

7 AGE: Years 63 Months 4 Days 19 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER: John T. Brown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ga

12 MAIDEN NAME OF MOTHER: Julia A Perkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ga

14 Informant (Address): Lenna W Delbridge 1906 Longwood St

15 [illegible] 1930 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) H. Louis Taylor M. D.

(Coroner)

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Danville, Va Date of Burial Mar 6 1930

20 UNDERTAKER: J. M. Cook ADDRESS 1217 E Fort Ave

very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54732

CERTIFICATE OF DEATH.

90 E 54732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1738 N. Broadway (ST.) 8-17 (WARD)

2-FULL NAME Stefton D. Hull

(a) RESIDENCE NO. 1738 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bella A Cullison

6 DATE OF BIRTH (month, day, and year) Oct 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Stefton D Hull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Hazard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Maude Moore

(Address) 1921 E North ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1929, to March 4, 1930

that I last saw h[illegible] alive on March 3, 1930

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular pleural disease (Ulcerative Sclerosis) + advanced years

(duration) 4 yrs. 4 mos 29 ds.

CONTRIBUTORY (Secondary) Not Known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I K Gonzales, M. D.

3-5, 1930 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	March 6 1930
UNDERTAKER John Oldden's Sons	ADDRESS 1900 Eutaw Place

R 5

CAUTION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54733

CERTIFICATE OF DEATH

E 54733

REGISTERED NO. 73

1—PLACE OF DEATH Home for Incurables - 40th & Keswick Rd. ST. 18-16 WARD)
CITY OF BALTIMORE: (No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Worley

(a) RESIDENCE NO. 113 N. Carey ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 5, 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Lady
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster Maryland

PARENTS

10 NAME OF FATHER William Worley
11 BIRTHPLACE OF FATHER (city or town) York (State or country) Pennsylvania
12 MAIDEN NAME OF MOTHER Lina Mathers
13 BIRTHPLACE OF MOTHER (city or town) Westminster (State or country) Maryland

14 Informant Home for Incurables Records
(Address) 40th & Keswick Road

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930, to March 4, 1930, that I last saw her alive on March 4, 1930, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Myelitis with complete paralysis below the dorsal spine.

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) secondary anaemia & general inanition (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? No
(Signed) H. S. Willis M. D.
19 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery
20 UNDERTAKER John O. Mitchell & Sons

DATE OF BURIAL March 6 1930
ADDRESS 1900 Eutaw Place

Important. See instructions on back of certificate.

MAR 5 1930

Spec.—1-10 21—M&T—1500 Blks.

E 54734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1117 E 54734

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Avenues ST. 16-67 WARD)

2-FULL NAME Mrs Anne Graydon Carr

(a) RESIDENCE NO. 723 Rosedale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Carr

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1875

7 AGE Years 54 Months 4 Days 18 20

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER James Graydon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Eliz Bracey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John Carr

(Address) 723 Rosedale St

15 Date received MAR 6 - 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-5 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-13 , 1930 , to 3-5 , 1930 ,

that I last saw her alive on 3-5 , 1930 ,

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis, ruptured with Peritonitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 25 38

Was there an autopsy? no

What test confirmed diagnosis? Section of appendix

(Signed) Ernest Spencer jr , M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL Mar 8 1930

20 UNDERTAKER Wm J Tuckner & Sons ADDRESS N. Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 54735

CERTIFICATE OF DEATH.

129

REGISTERED NO.

E 54735

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Archerstooly St. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Adelaide Hartwig

(a) RESIDENCE No. 1804 Archerstooly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William R Hartwig

6 DATE OF BIRTH (month, day, and year): Nov 12 1870

7 AGE: Years 59 Months 3 Days 23 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House 037

(b) General nature of industry, business, or establishment in which employed (or employer): Wood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Kimpel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Margaret Stallings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Wm R Hartwig

(Address) 1804 Arunmel Ley

15 FILED MAR 6 - 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1930, to Mar 5, 1930, that I last saw her alive on Mar 4, 1930, and that death occurred, on the date stated above, at a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Thos C. Blake, M. D.

, 19 (Address) 719 Med Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Mar 8 1930

20 UNDERTAKER: H J Eschenburg Sons

ADDRESS: N & Paca

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54736

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54736

CERTIFICATE OF DEATH.

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3016 Mary Ave. St., 43rd WARD)

2-FULL NAME Grace D. Mettee

(a) RESIDENCE NO. 3016 Mary Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of H. Kennedy Mettee

6 DATE OF BIRTH (month, day, and year) Dec. 10 1866

7 AGE	Years	Months	Days 24	If LESS than 1 day, hrs. or min.
	63	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alexander Albaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) At Sea

12 MAIDEN NAME OF MOTHER Henriette Schaeffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Anna Catherine Albaugh

(Address) 3016 Mary Ave.

15 Filed MAR 6 - 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1930 to Mar 4 1930, that I last saw h alive on Mar 3 1930, and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage with left hemiplegia

(duration) — yrs. — mos 13 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) abt 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Phys. exam.

(Signed) Chas. J. Keller, M. D.

3/5 1930 (Address) 2226 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL Mar. 6 1930

UNDERTAKER Wm. J. Fickenscher & Sons

ADDRESS Norde Pa

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

54737

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 E 54737

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2803 Roslyn Ave ST. 15-61 WARD)

2-FULL NAME John Henry Eiser

(a) RESIDENCE NO. 2803 Roslyn Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lelith Eiser

6 DATE OF BIRTH (month, day, and year) Oct 28-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 68

(b) General nature of industry, business, or establishment in which employed (or employer) Rugs-Carpets

(c) Name of employer McDowell Co

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Eiser

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary L.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Mr. Lelith Eiser

(Address) 2803 Roslyn Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb-10th, 1930, to March 3, 1930,

that I last saw him alive on Mar 3, 1930,

and that death occurred, on the date stated above, at 2:30 PM

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Cardiac Insuffiency

(duration) yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary) Coronary Sclerosis Gastritis 30 yrs.

(duration) yrs. Some time mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Laboratory

(Signed) J. Mitchell Jones, M. D.

, 19 (Address) 2802 Roslyn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Mar 6, 1930

20 UNDERTAKER H. J. Justice & Son

ADDRESS N. & Pa

TION is very important. See instructions on back of certificates.

MAR 6-1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54738

CERTIFICATE OF DEATH

1930 E 54738

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Providence Hosp. St. 1622 Ward)

2-FULL NAME Walter Ware

(a) RESIDENCE NO. 1643 W. Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Apr 22 1899.

7 AGE: Years 30 | Months 11 10 | Days 9 10 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Driver Truck
(b) General nature of industry, business, or establishment in which employed (or employer) 073
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jas Ware.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Harriet Frazier

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs. Elizabeth Ware
(Address) 1643 Lanvale St

15 Filed ....., 19.... Per ..... Registrar

C. HAMPSON JONES, M. D.

MAR 6 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Mar 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Hemorrhage due to stab wound of Chest. Heart & Lung
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Pointed Knife)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1643 W Lanvale

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) C. Hampson Jones M. D.

Mar 26 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem. | DATE OF BURIAL: Mar 6 1930

20 UNDERTAKER: John H. Joachim | ADDRESS 1037 Hand St.

THIS SPACE MUST BE CAREFULLY SCANNED, AND SHOULD BE STATED EXACTLY. PHYSICIAN SHOULD BE CAREFUL TO USE PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54739 5/1 E 54739

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Taylor Johnson

(a) RESIDENCE NO. 1410 Druid Hill ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F Johnson

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co Md (State or country)

PARENTS

10 NAME OF FATHER Geo Johnson

11 BIRTHPLACE OF FATHER (city or town) Howard Co (State or country) Md

12 MAIDEN NAME OF MOTHER Millie Kelley

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country) Md

14 Informant Mary Ballard (sister)

(Address) 634 Sayrgate ave

15 Filed ... 19 ... C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1930, to March 3, 1930, that I last saw h.. alive on March 3, 1930 and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonic Tuberculosis

Endocarditis

(duration) yrs. 1½ mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: Mar 6, 1930

20 UNDERTAKER: Mrs. Kate R. Williams

ADDRESS 322 N. Schroeder St

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54740

CERTIFICATE OF DEATH.

129 E 54740

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1441 William 24-33 ward

2-FULL NAME Jos. L. Lowder

(a) RESIDENCE NO. 1441 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Lowder

6 DATE OF BIRTH (month, day, and year) Jan 29 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Sealer N.T.

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland.
(State or country)

PARENTS

10 NAME OF FATHER John Lowder

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER A. Greenwell

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's
(State or country) County Md

14 Informant Albert Lowder
(Address) 1441 William St.

15 Filed MAR 6 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3. 2. 30 19

17 I HEREBY CERTIFY, That I attended deceased from 1924, 19 ..., to 3. 2. 30, 19 ..., that I last saw h ... alive on 3. 2. 30, 19 ..., and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

6 Chronic Parenchymatous Nephritis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Microscopic

(Signed) Chas B. Fowler, M. D.

3.4.30 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill DATE OF BURIAL 3/6 19 30

20 UNDERTAKER John J. Fahey & Son ADDRESS 1315 Eagle

CAUSE OF DEATH must be given in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—8-16-29—L. F. S.—100 Bks.

234E54741 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 100-001 ✓

CERTIFICATE OF DEATH

REGISTERED NO. E 54741

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 24-35 WARD)

2—FULL NAME Clarence Gardner

(a) RESIDENCE NO. 1238 E. Fort ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/10/27

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mildred Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parents (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 6 - 1930, 19 H. LAMAR JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5-1930

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1930 to March 5, 1930, that I last saw him alive on March 5, 1930 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, Bilateral

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Howard C. Knapp, M. D.

May 5, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 5/8 1930

20 UNDERTAKER Wellman Cook — ADDRESS 121 St Paul

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

19 37

E 54742

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Md Gen. Hosp. St., 15-21 Ward

2-FULL NAME Jacob Dackman

(a) RESIDENCE NO. 1664 W. North Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., If of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Dackman

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
51	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery business
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Jack Lev
(Address) 1439 E. Balt St.

15 Filed ... 19... Registrar

1930 CLARENCE JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 3rd 1937

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemiplegia due to gunshot wound of Left Femoral Artery (duration) ... yrs. few hours

CONTRIBUTORY (Secondary)

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 614 Dolphin

Did an operation precede death? No Date of ...

Was there an autopsy? yes

What test confirmed diagnosis? Regular

(Signed) ... M. D.

March 3 1937 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Henry Rus

DATE OF BURIAL 3/ 1937

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Balt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54743

161-001 E 54743

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hop. Balto Md REGISTERED NO.

CITY OF BALTIMORE: (No. 3111 H. Balto St., or (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eleanore Hewitt

(a) RESIDENCE NO. 1647 Pallman Park Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Feb 24, 1930.

6 DATE OF BIRTH (month, day, and year) Feb 24 1930

7 AGE	Years	Months	Days 11	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Premature child

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Earl Hewitt.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Sweeten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Chart & Father

(Address) above

15 Filed APR 6 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 5 2:30 P.M., 1930, to Mar 5, 10:00 PM 1930;

that I last saw h e alive on Mar. 5, 1930, 1930,

and that death occurred, on the date stated above, at 10:00 P— m.

The CAUSE OF DEATH* was as follows:

Premature of 6½ mo - (hardly viable) Nutritional cause.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Severe malnutrition

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & history.

(Signed) A. M. Swarbrick M. D.

Mar 5 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bel Air Cem

DATE OF BURIAL Mar 6 '30

20 UNDERTAKER John Ellis

ADDRESS 2008 Eutaw

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54744

90 E 54744

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1545 Myrtle St. 11-20 Ward)

2-FULL NAME Maggie E. Tillman

(a) RESIDENCE NO. 1545 Myrtle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmal	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 15.

6 DATE OF BIRTH (month, day and year) Feb 19 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	64	—	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Jas. Tillman

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Parsons

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Jane Tillman
(Address) 1545 Myrtle St

15 Filed APR 6 - 1930 18 C. HARRY JONES Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Leland Mackenzie, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL* Laurel Cemetery DATE OF BURIAL March 1930

20 UNDERTAKER Frank E. Wirth ADDRESS 1700 Pennsylvania Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

Kidwell

E 54745

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 ✓

E 54745

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp. ST. 9-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Kidwell

(a) RESIDENCE NO. 1217 E Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Essie Kidwell

6 DATE OF BIRTH (month, day, and year) April 4. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) C + P. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER George W. Kidwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington

12 MAIDEN NAME OF MOTHER Rebecca Lupton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Beula H. Gabrinetz

(Address) 8013 Rogers Ave. Hamilton

15 Filed APR 5 - 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/3/30.

17 I HEREBY CERTIFY, That I attended deceased from 2/26, 1930, to 3/3, 1930, that I last saw h[illegible] alive on 3/3, 1930, and that death occurred, on the date stated above, at 1030 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clin and autopsy

(Signed) Henry F. Merrick, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery.

DATE OF BURIAL March 5. 1930

20 UNDERTAKER George L. Rush

ADDRESS 1725 Harford Ave

Be important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54746 1794 E 54746

CERTIFICATE OF DEATH

E 54746

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Joseph Hospital St., 9-18 Ward)

2-FULL NAME Frances T. Neubauer

(a) RESIDENCE NO. 1703 N. Ensor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6/1924

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	4	26 26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none (caught
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Frederick A. Neubauer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Frances Short

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant F.A. Neubauer
(Address) 1703 N. Ensor St

15 Filed ..... 19.. Registrar

MAR 6 1930 C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4/30 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burbs over body- Clothes
while playing with cigarette lighter

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

3/6/30 (Address 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rood - Mau 1

DATE OF BURIAL 3-1930

20 UNDERTAKER D J Lyter - 156 Eutaw

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 54747

E 54747

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2721 Oak Street ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth B. Plowman

(a) RESIDENCE NO. 2721 Oak Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1907

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	5	25 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Howard A. Barnes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Jacobs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mr William Plowman
(Address) 2721 Oak Street

15 Filed MAR 6 1930 19 H. [illegible] Jones, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 5th, 1928 to Mar. 4th, 1930, that I last saw her alive on Mar. 4th, 1930 and that death occurred, on the date stated above, at 11.45 P.m.

The CAUSE OF DEATH* was as follows:

a Tubercular Ecolosis
Bones abscess.
Pulmonary Tuberculosis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes. Date of Oct 15th 1929

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) George H. Cross, M. D.

, 19 (Address) 28 W 25th St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	March 7, 1930

20 UNDERTAKER E. Leroy Stiffler, & Inc. ADDRESS 125 E. North Ave

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 E 54748

REGISTERED NO. E 54748

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Joseph's Hosp ST. 21-29 WARD)

2-FULL NAME Adam Schneider

(a) RESIDENCE NO. 1203 N. Cron ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or ~~Divorced,~~ (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Ellie Schneider

6 DATE OF BIRTH (month, day, and year): Nov. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	4	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways Balto Md.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER B. Schneider

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Wm Rowe
(Address) 4033 Fred. ave.

15 Filed MAR 6 - 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-4 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-7, 1930 to 3-4, 1930.

that I last saw ~~him~~ alive on 3-3, 1930,

and that death occurred, on the date stated above, at 11:10 AM.

The CAUSE OF DEATH* was as follows:

Cancinoma of the Jaw

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Anaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Lindsay Wood M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 3/7/30 19

UNDERTAKER: Geo Leimbach

ADDRESS: 1908 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54749

HEALTH DEPARTMENT—CITY OF BALTIMORE

54 E 54749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) (St.) 17-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Erécksen Brown

(a) RESIDENCE NO. 1030 Wilmare Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Sept. 6, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4-30

17 I HEREBY CERTIFY, That I attended deceased from 2-25-30, 19, to 3-4-30, 19,

that I last saw him alive on 3-4-30, 19,

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra & Psychosis

Vincents Angina

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Alcoholism, Chronic; Broncho-Pneumonia (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren M. McLean, M. D.

3-5, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wash DC

DATE OF BURIAL 3/8 1930

20 UNDERTAKER Frank Kennedy 5784 Reisterstown Rd

ADDRESS

TION is very important. See instructions on back of certificate.

C. HINCHINGS JONES, M. D.

MAR 6 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54750

CERTIFICATE OF DEATH

90 E 54750

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5221 Denmore Ave St. 27-55 Ward)

2-FULL NAME Ida E. Waters

(a) RESIDENCE NO. 5221 Denmore Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE: Years 62 | Months | Days | IF LESS than 1 day ..hrs. or ..min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. Md
(State or country)

PARENTS

10 NAME OF FATHER Alf Hewson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Anne Bruce

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Annie Williams
(Address) 5221 Denmore Ave

15 Filed ..., 19.. H... C. Register

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held a Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows: Valvular Disease of Heart

(duration) ..yrs. ..mos. ..da.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) ... M. D.

3-5-1930 (Address) 3632 Boston Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Thomas Cem

DATE OF BURIAL: 3/6 1930

20 UNDERTAKER: Samuel I. Hensley

ADDRESS 578 Bible

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 6 - 1930

Spec.—1-30—M. & T.—250 Bks.

E 54751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ E 54751

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1029 S. Bouldin ST., 26 WARD)

2-FULL NAME Margaret E. Albrecht.

(a) RESIDENCE NO. 1029 S. Bouldin ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephan J. Albrecht

6 DATE OF BIRTH (month, day, and year) Feb. 14 1858

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	71		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. Md. (State or country)

PARENTS

10 NAME OF FATHER Conrad Koerner

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Anna M. Kraut

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Stephan J. Albrecht

(Address) 1029 S. Bouldin St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4, 30

17 I HEREBY CERTIFY, That I attended deceased from 2/6, 1930, to 3/4, 1930, that I last saw her alive on 3-4, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. 3 da.

CONTRIBUTOR (Secondary) Chronic Interstitial Nephritis

(duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller M. D.

3/6, 1930 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	March 7 1930
20 UNDERTAKER Lilly & Geier Inc	ADDRESS 403 S. Hoyt St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 54752 HEALTH DEPARTMENT—CITY OF BALTIMORE 104 E 54752

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Thomas

(a) RESIDENCE NO. 331 Forrest St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Thomas

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Of

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Joseph Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Records of (Address) Balto. City Hospitals

15 Filed MAR 6 1930 19 C. HARRISON JONES, M. D. Registrar

R 0-4320

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3-30

17 I HEREBY CERTIFY, That I attended deceased from 2-28-30, 19, to 3-3-30, 19, that I last saw h... alive on 3-3-30, 19, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Gangrene L. Lung

(duration) yrs. mos 13 da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 13 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

3-4, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

UNDERTAKER B. Commissioner of Health

ADDRESS MAR 6 - 1930

...TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 54753

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 54753

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 125 S. Calvert St., 70-69 Ward)

2-FULL NAME Christian F. Kirch

(a) RESIDENCE NO. 125 S. Calvert St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mch 3/30

7 AGE	Years	Months	Days	IF LESS than 1 day 5 hrs. or min.
	—	—	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 000
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Christian F. Kirch

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Eva E. Jacobs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs Eva Kirch
(Address) 125 S Calvert St

15 Filed 19 Registrar

MAR 6 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Brosius M. D.

3/5. 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER
Commissioner Health

ADDRESS

MAR 6 - 1930

C. HERMON Jones, M. D.

Registrar

1922

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Roy F Collier

HEALTH DEPARTMENT—CITY OF BALTIMORE

155 V

E 54754

E 54754

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Union Memorial Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calvert & 33rd ST., 8-1 WARD)

2—FULL NAME Roy F. Collier

(a) RESIDENCE NO. 1409 N. Bond ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 5 mos. 5 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Helen Collier

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	33	5	5-7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bill-poster 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Collier

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sally Crockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records.

(Address)

15 Filed MAR 6 - 1930, 19 C. BAMBERTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1930, to Mar. 5- 1930

that I last saw him alive on Mar. 5- 1930

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis, acute, femur, left.
Sinositis, acute, hip joint, left.

(duration) about 28 ds.

CONTRIBUTORY (Secondary) Syphilis (duration) about mos. 18 ds.

18 Where was disease contracted if not at place of death? St Louis.

Did an operation precede death? Yes Date of 2/11/30 & 2/17/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operative findings - Blood Culture

(Signed) William R. Hargett, M. D.

Mar. 5- 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL 3/7 1930

20 UNDERTAKER Henry W. Mears and Son — ADDRESS 805 N. Calvert

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Bush

E 54755

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 S Union St, Ward 19-28)

REGISTERED NO. 1901 E 54755

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laurance Bush

(a) RESIDENCE NO. 321 S Union ST, ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
(a) HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 16 - 1929

7 AGE: Years ..... Months 7 Days 18

If LESS than 1 day, ... hrs or ... min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Laurence Bush

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wilmington N C

12 MAIDEN NAME OF MOTHER: Pearl Bowry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Port New Va

14 Informant: Pearl Bowry Bush

(Address) 321 S Union

15 Filed 6-1930

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-6-1930

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to March 5, 1930,

that I last saw h alive on March 30, 1930

and that death occurred, on the date stated above, at 6:25 a m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

Bilateral

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. J. Fiske M. D.

(Address) 1628 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — DATE OF BURIAL: 3-7 1930

20 UNDERTAKER: Joseph A Lively — ADDRESS: 409 N. Mount St

CAUSES OF DEATH. See instructions on back of certificates. TION is very important

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54756

CERTIFICATE OF DEATH.

100 E 54756

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1639 Walbrook ave. 5-21 (WARD)

2-FULL NAME Annie Mitchell

(a) RESIDENCE NO. 1639 Walbrook ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Mitchell

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years 56 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos. H. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Rebecca Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Helen Johnson

(Address) 1639 Walbrook ave

15 6-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) 3/4/30

17 I HEREBY CERTIFY, That I attended deceased from 2-26-30, to 3-4-30, 1930

that I last saw h[illegible] alive on 3/3/30, 19

and that death occurred, on the date stated above, at 4:45 a.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Acute Dilatation of the Heart

(duration) yrs. mos. 8 da.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 529 Hurd ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Balto

DATE OF BURIAL 3-7 1930

20 UNDERTAKER Geo T. A. Gibson

ADDRESS 1733 Penn ave Hilton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6

Spec.—1-30—M. & T.—250 Blks.

E 54757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 54757

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 76-37 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Taylor

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond

(State or country) Va.

PARENTS

10 NAME OF FATHER Henry Taylor

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Virgie Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Records of

(Address) B.C.H.

15 Filed 6 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2-27-30

17 I HEREBY CERTIFY, That I attended deceased from 2-6-30, 19..., to 2-27-30, 19...,

that I last saw him alive on 2-27-30, 19...,

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ... yrs. over 2 mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. over 2 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? Yes Yes

What test confirmed diagnosis? Clinical Autopsy

(Signed) Warren McLean, M. D.

2-27, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITA

DATE OF BURIAL ... 19

20 UNDERTAKER Commissioner Health.

ADDRESS MAR 6 - 1930

IMPORTANT: See instructions on back of certificates.

443-1

Spec.—1-10-21—M&T—1500 Blks.

E 54758

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54759

CERTIFICATE OF DEATH.

124

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (Ward) 15-23

2-FULL NAME Mamie Catanese

(a) RESIDENCE NO. 1108 Lawrence ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Joseph Catanese

6 DATE OF BIRTH (month, day, and year) Aug 15 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER S. Bolodo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Bernardo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Josephine DeCola (Address) 2948 Reisterstown Road

15 6-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/30 19

17 I HEREBY CERTIFY, That I attended deceased from 2/28/30, 19 . to 3/5/30 , 19 .

that I last saw h alive on 3/5/30 , 19 ,

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Uraemia Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) cardiac decompensation (duration) yrs. 3 mos hrs

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 3/3/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M Blumberg, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Monday 1930

20 UNDERTAKER Frank V Pipitone — ADDRESS 2817 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 54759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 54759

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1912 Ridgewood St. 15-21 WARD

2-FULL NAME Mary Virginia West

(a) RESIDENCE NO. 1912 Ridgewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 7 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia (State or country)

PARENTS

10 NAME OF FATHER James W. West

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bessie H Bole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant James W. West

(Address) 1912 Ridgewood Ave

Filed 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch. 3 1930 to Mch 4 1930, that I last saw her alive on Mch. 4 1930, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Int. of Lungs.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic nephritis & Heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? expectoration

(Signed) E. E. Smith, M. D.

3/5 1931 (Address) 1605 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stafford Court House Va

DATE OF BURIAL Mar 7 1930

20 UNDERTAKER Frank Dyer

ADDRESS 1600 W North Ave

TION is very important See instructions on back of certificates.

R

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 54760

REGISTERED NO. E 54760

1—PLACE OF DEATH Md. General Hospital 34-57
CITY OF BALTIMORE: (No. ST. WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank J. Higgins

(a) RESIDENCE NO. Chilham Rd. - Mt. Wash WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia B. Mrs. Frank J. Higgins

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
46 47	47	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Traffic Supt. for
(b) General nature of industry, business, or establishment in which employed (or employer) Telephone Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Conn.

PARENTS

10 NAME OF FATHER Joseph Higgins
11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.
12 MAIDEN NAME OF MOTHER Catherine Houchin
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant Hospital Records
(Address) Maryland General Hospital

15 Filed 6-1930 C. HAMPSON JONES, M. D. Registrar
By: RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/30

17 I HEREBY CERTIFY, That I attended deceased from 2/18, 1930, to 3/5, 1930, that I last saw h. alive on 3/5, 1930 and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular-renal disease (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

3/5/30 (Signed) Jos. A. Sympson, M. D.
(Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery
UNDERTAKER D. Joseph Cook

DATE OF BURIAL Mar. 8 1930
ADDRESS 1003 West Baltimore St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54761

CERTIFICATE OF DEATH

185 E 54761

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 Eutaw Place ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christina Isabelle Ziegler

(a) RESIDENCE NO. 1739 Eutaw Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 1, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Charles Siegmund

(Address) 1739 Eutaw Place

15 Filed MAR 6 1930, 19 Per Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 23, 1929, to March 5, 1930, that I last saw her alive on March 5, 1930, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Comet, Fractured Hip Joint

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Deflection & Exhaustion (duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. L. Dashiell, M. D.

3/6, 1930 Address) 848 Cathedral St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL Mar. 7 1930

20 UNDERTAKER Cook

ADDRESS 1003 West Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

AR

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54762

E 54762

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2528 Mc.Eldery St ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME M.Alicia Lehky

(a) RESIDENCE NO. 2528 Mc.Eldery St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16/27

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Lehky

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dorothy Reitz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Joseph Lehky
(Address) 2528 Mc.Eldery St

15 Filed MAR 6-1930, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1930, to Mar 5-, 1930,

that I last saw h.i/7 alive on mar 5-, 1930

and that death occurred, on the date stated above, at 1.15 P.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 11 da.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Abram J. Bleeheimer, M. D.

, 19 (Address) 2700 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Mar.7 19 30

20 UNDERTAKER Frank Cvach & Son 1906

ADDRESS Ashland Ave.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54763

48 E 54763

CERTIFICATE OF DEATH

REGISTERED NO. 25-77

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 Elmtree ST., 25 WARD)

2—FULL NAME Mathias Michael Hrdlicka

(a) RESIDENCE NO. 1515 Elmtree ST., 25 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth 74 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Hrdlicka

6 DATE OF BIRTH (month, day, and year): February 26 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Mathias Hrdlicka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Emma Mecherer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Mary Hrdlicka
(Address): 1515 Elmtree St

15 Filed 19 C. HAMPSON JONES, Registrar

MAR 6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 5 '30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1930, to Mar. 5, 1930, that I last saw him alive on Feb. 26, 1930 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Face.

(duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Jno. S. Scott, M. D.

Mar. 5, 1930 (Address) 485 S. Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — DATE OF BURIAL: Mar. 9 1930

20 UNDERTAKER: J. B. Frank & Son — ADDRESS: 1406 Eastern Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54764 31 E 54764

CERTIFICATE OF DEATH

E 54764

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N. Madeira St ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christina Antonie Prochaska

(a) RESIDENCE NO. 916 N. Madeira St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Proska

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Frank Stemberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Joseph Proska

(Address) 916 N. Madeira St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5/30

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1929 to March 5, 1930,

that I last saw her alive on March 5, 1930

and that death occurred, on the date stated above, at 6 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam

(Signed) Dr. Johnson, M. D.

, 19 (Address) 220 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Mar. 8 1930

20 UNDERTAKER Frank Cvach & Son

ADDRESS 1906 Ashland Ave

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54765 ✓ 101-09 E 54765

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME G. Edward Wright

(a) RESIDENCE NO. Aberdeen, Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Sept. 7-1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo E Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma E James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Geo E Wright

(Address) Aberdeen Md

15 Filed 6-1930 C. HIMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to March 6, 1930, that I last saw h alive on March 6, 1930 and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia (left lobar lobe).

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bacteraemia (pneumococcic) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Aberdeen, Md.

Did an operation precede death? No Date of

Was there an autopsy? Refused.

What test confirmed diagnosis? Blood cultures

(Signed) M. McClain, M. D.

3/6, 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harford Memorial Cemetery

DATE OF BURIAL Mar 8 1930

UNDERTAKER Wm J Gardner Sons

ADDRESS N. Y. Ave

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 54766

CERTIFICATE OF DEATH.

182 B 54766

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Carrie St. 4-6 Ward)

2-FULL NAME Wm E. Stevens

(a) RESIDENCE NO. 114 S. Frederick St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
56	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Pocomoke City Md.

PARENTS

10 NAME OF FATHER Franklin Stevens

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pocomoke City Md.

12 MAIDEN NAME OF MOTHER Alexine Towsend

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pocomoke City Md.

14 Informant Vermon P. Stevenson

(Address) Pocomoke City Md.

15 Filed Jan 6 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Probable Drowning Acc

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

Signed C. E. Shades M. D.
(Coroner)

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pocomoke City Md Date of Burial March 7 1930

20 UNDERTAKER John C. Miller ADDRESS 2435 E Oliver

Be sure the entry supplied is one that may be properly classified. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be very important. See instructions on back of certificate.

R 6

Cor.—12-9-25—A Co.—200 Bks.

54767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Franklin Square Hospital St. 18-29 Ward

2-FULL NAME Doris Levona Simmers

(a) RESIDENCE NO. 134 S. Schroeder St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) October 20, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank D. Simmers

11 BIRTHPLACE OF FATHER (city or town) Linville

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary E. Beery

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Rockingham Co., Va.

14 Informant Mr. Frank D. Simmers

(Address) 134 S. Schroeder St.

15 6-1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

(Signed) Chas. W. Brooks M. D.
(Coroner)

3/6 1930 (Address) 3601 Third St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State Life ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial Mar. 8 1930

20 UNDERTAKER Booth Cook ADDRESS 1003 West Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54768

CERTIFICATE OF DEATH

REGISTERED NO. E 54768

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hosp St. 25-72 188-203 (Ward)

2-FULL NAME Glen Gwinn

(a) RESIDENCE NO. Ashford Ala St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred None mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Lou Knowles

6 DATE OF BIRTH (month, day, and year) Lou Knowles dale - 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
36	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ashford Ala
(State or country)

PARENTS

10 NAME OF FATHER Thad M Gwinn

11 BIRTHPLACE OF FATHER (city or town) Ashford Ala
(State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Ashford Ala
(State or country)

14 Informant M. Thad M. Gwinn
(Address) Ashford Alabama

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar
By DKH

R 6-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Struck & Knocked down by Auto while walking along road

Hr (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

Fract L. Humerus (duration) Shock yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wash Rd at Walthorp

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Dunn M. D.

3/4, 1930 (Address) 2939 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Anniston Alabama	3/8/1930
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Hollins St

(Do not write in this space. Any words written here will be illegible. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—1-30—M. & T.—250 Blks.

E 54769 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 54769

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 300 N. Bridle ST. 11-24 (WARD)

2-FULL NAME Mary E. Cronhardt

(a) RESIDENCE NO. 300 W Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Cronhardt

6 DATE OF BIRTH (month, day, and year) June 25 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Fred Leinsy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Katherine Sutton (Address) 856 W Mosher

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1928, to Mar 5, 1930.

that I last saw her alive on Mar 5, 1930.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 1 yrs. 4 mos 25 da.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Petticoan M. D.

19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	March 7 1930
20 UNDERTAKER John O Mitchell & Son	ADDRESS 1900 Eutaw Place

THION is very important See instructions on back of certificate.

5-1930 C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54770

CERTIFICATE OF DEATH

129 E 54770

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. 22-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Ernest R. Loane

(a) RESIDENCE NO. Mt. Washington, Balto. Co. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. E. R. Loane -

6 DATE OF BIRTH (month, day, and year) May 20, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) Own ? Oil

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jabez W. Loane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Ash King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. E. R. Loane

(Address) Mt. Washington, Balto. Co.

Filed 6-1930, 19

Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1930, to Mar. 6, 1930

that I last saw him alive on Mar 6, 1930

and that death occurred, on the date stated above, at 1 00 P. M.

The CAUSE OF DEATH* was as follows:

Hypertension & Chronic Interstitial nephritis,

(duration) 2 yrs. + mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bl. Chem, etc.

(Signed) A. M. Stafford Jr, M. D.

(Address) 814 N. Eut.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	March 8 1930
20 UNDERTAKER	ADDRESS
John O Mitchell & Sons	1900 Eutaw Place

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54771

CERTIFICATE OF DEATH

73 E 54771

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Wise

(a) RESIDENCE NO. 1705 N Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John Phillips

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisville Va

PARENTS

10 NAME OF FATHER Henry Wise

11 BIRTHPLACE OF FATHER (city or town) Louisville (State or country) Va

12 MAIDEN NAME OF MOTHER Julia P

13 BIRTHPLACE OF MOTHER (city or town) Louisville (State or country) Va

14 Informant Mozelle Ward (Daughter)

(Address) 2306 Etting St

15 FILED 6-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-5-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930, to March 5, 1930, that I last saw h alive on March 5, 1930 and death occurred, on the date stated above, at 7 30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Myelitis

(duration) about 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Pleasant Va.

DATE OF BURIAL 3/7, 1930

21 UNDERTAKER Mrs. Geo. Rad Colland

ADDRESS 1631 Druid

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

White

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-601 ✓

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1229 Druid Hill Ave St. 11-24 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie White

(a) RESIDENCE NO. 1229 Druid Hill Ave ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs mos ds How long in U. S., if of foreign birth? yrs mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ? 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	59	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS
10 NAME OF FATHER Danl White
11 BIRTHPLACE OF FATHER (city or town) (State or country) md.
12 MAIDEN NAME OF MOTHER Rebec. Kelso
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Raymond Carpenter
(Address) 1229 Druid Hill Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1930, to March 4, 1930, that I last saw h alive on March 4, 1930, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio - Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Wheatley M. D
3/6, 1930 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery
DATE OF BURIAL 3/7/30

20 UNDERTAKER Mrs. Geo. E. Holland
ADDRESS 1617 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

R 5-1930

Cor.—10-10-29—A Co.—100 Bks.

E 54773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001 E 54773

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1614 Ruxton Ave St. 15-6 Ward)

2-FULL NAME Gertrude Hendrason

(a) RESIDENCE NO. 1614 Ruxton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Hendrason

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 027
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER David Schwartz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Frieda —

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Lewis
(Address) 1439 E. Baltimore St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Asphyxia, Illuminating Gas Ludden

(duration) yrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. Blank M. D.

(Address) Mar 6th 1930 Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 3/7 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

234166

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 54774

E 54774

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 45-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eleanor Gordon

(a) RESIDENCE NO. 1727 N Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 17 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Lena Schuman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 7 - 1930 H. L. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930, to March 6, 1930

that I last saw h alive on March 6, 1930

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. O. G. Wooden, M. D.

3-6, 1930 (Address) John Hopkin Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 3/7 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 54775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 54775

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) Sinai Hospital (St.) 18-24 (Ward)

2-FULL NAME Mrs Fanny Racusin

(a) RESIDENCE NO. 861 Holland ST ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Racusin

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 54 — Months — — Days — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Harry Levin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): John Racusin 861 Hollins St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3 6 1930

17 I HEREBY CERTIFY, That I attended deceased from February 5, 20 March 6, 1930, that I last saw her alive on 3-6, 1930, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

Diabetes Mellitus

Hemiplegia (R)

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) I. Cohen M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 3/7 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 439 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXPLANATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 54776

CERTIFICATE OF DEATH

E 54776

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH City Hospital

City of Baltimore: (No. 22-30 St. Ward)

2-FULL NAME Est J. Byrnes

(a) RESIDENCE NO. 5 W. Lee St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 24. 1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39.	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Dr
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER George J. Byrnes

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Addie Garrett

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Addie Cromwell
(Address) 5 W. Lee St.

15 Filed AR 7 - 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? City Chemist

(Signed) Geo. Curtis Blades, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	March 8 1930
20 UNDERTAKER	ADDRESS
Fred A. Wanerson	703 Bway

THE PHYSICIAN OR CORONER making this certificate will be responsible for it. It should be carefully prepared. It may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 54777

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

100 E 51777

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 673 W Fayette St. 25 WARD)

2-FULL NAME Joseph John Rice, Jr.

(a) RESIDENCE NO. 673 W Fayette St., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28 1924

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 673 W Fayette St Baltimore

PARENTS

10 NAME OF FATHER Jos. J. Rice

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Emma Jane Beck

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant (Address) Joseph Rice 673 W Fayette

15 Filed ..... 19 ..... Registrar

CAUSE OF DEATH—See instructions on back of certificates. IMPORTANT is very important

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1930, to Mar 5, 1930, that I last saw him alive on Mar 5, 1930, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows: Cardiac failure

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Findings of attending physician and autopsy

(Signed) John MacMurray M. D.

, 19 (Address) 2141 Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 3-7-30 19

20 UNDERTAKER Chas. B. Kuchausteas

ADDRESS 631 S. Paca St

H. HAMILTON JONES M. D.

MAR 7 1930

Cor.—1-12-23—M&T—100 Bks.

E 54778

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54778

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto Country Club ST. 12-4-9 WARD

2-FULL NAME Findley Hyland Burns Bullock

(a) RESIDENCE NO. Tudor Arms Apts. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? 61 yrs. 1 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Thomas Bullock

6 DATE OF BIRTH (month, day, and year) January-24-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	1	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chief of Voucher Bureau
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R.R.
(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John S. Bullock
11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md
12 MAIDEN NAME OF MOTHER Catherine Davis
13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mr. Wm. A. Bullock (bro.)
(Address) Tudor Arms - city.

Filed MAR 7 - 1930 HARRY JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Coronary Disease of Heart
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrissey, M. D.
3/6/30 (Coroner.) (Address) 1632 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., Hour ds. In the State 61 yrs., 1 mos., 9 ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Tudor Arms Apts.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Lawn Cemetery DATE OF BURIAL Mar 8 1930

20 UNDERTAKER Stewart Mortuary Co ADDRESS Balto

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

54779

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

90E 54779

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 608 N. Caroline St. 5-8 WARD)

2-FULL NAME Viola Campbell

(a) RESIDENCE NO. 608 N. Caroline ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married.

5a If married, widowed, or divorced (or) WIFE of Harry Campbell

6 DATE OF BIRTH (month, day, and year) July 7, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Wm-H. Green

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Annie N. Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Wm-H. Green father (Address) 608 N Caroline St

15 Filed 1930, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF Death

16 DATE OF DEATH (month, day, and year) Feb 4 · 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 30. to Feb 4 . 19 30.

that I last saw h alive on March 3 . 19 30.

and that death occurred, on the date stated above, at 7 45 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Severe Bronchitis 2 wks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

3/5 . 1930 (Address) 1429 Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathay Cemetery DATE OF BURIAL Mar 7 1930

20 UNDERTAKER Chas. H. Johnson ADDRESS 416 N. Caroline St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AR 7

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54780 ✓ 002 E 54780

CERTIFICATE OF DEATH.

E 54780

REGISTERED NO. 28-64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3017 Wayne Ave ST., (WARD)

2-FULL NAME Rufus Earl Christian

(a) RESIDENCE NO. 3017 Wayne Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Aline Christian

6 DATE OF BIRTH (month, day, and year) June 22, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Univ of Md

9 BIRTHPLACE (city or town) Warren

(State or country) Md

PARENTS

10 NAME OF FATHER Rufus Christian

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Belle Yater

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Mrs. Mary A Christian

(Address) 3017 Wayne Ave.

15 Filed 19 C. H. [illegible] JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1930, to Mar 5, 1930, that I last saw him alive on March 5, 1930, and that death occurred, on the date stated above, at 1.35 a m.

The CAUSE OF DEATH* was as follows:

Infection in nose followed by

Cavernous sinus thrombosis

thrombosis

Cavernous sinus (duration) 8 Hours mos ds.

CONTRIBUTORY (Secondary) infection of the nose (abscess) (duration) yrs. mos. 1 week ds.

18 Where was disease contracted if not at place of death? ?------

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & blood test

(Signed) Hall S Williams, M. D.

3/6/1930 (Address) 2220 Garrison ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Cem Va

DATE OF BURIAL Mar 7 1930

20 UNDERTAKER Wm J Tucker & Sons

ADDRESS Norfolk Va

MAR 7 - 1930

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54781 ★153 E 54781

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Ten ST., 345 WARD 33)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rufus Harrod

(a) RESIDENCE NO. Glenburnie, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 26 ds. How long in U. S., if foreign birth? 20 days yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced. HUSBAND of (or) ~~WIFE~~ of Alexina Harrod

6 DATE OF BIRTH (month, day, and year) July 20-80

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44 yrs	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thos Harrod

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Queen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alexina Harrod

(Address) Glenburnie Q.A.Co

15 Filed MAR 7 19 31 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to March 4, 1930, that I last saw h... alive on March 4, 1930 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Multiple abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

Card. failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood culture

(Signed) E. A. Kilsheimer M. D.

3-4-1930 (Address) 1213 Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Branch — DATE OF BURIAL Mch 7 1930

20 UNDERTAKER Sam'l N. Chase Wm — ADDRESS 400 Mosher

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54782 — 117 — E 54782

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Baltimore Wg ST. 15-56 WARD)

2-FULL NAME Benjamin F. Pierpont Jr.

(a) RESIDENCE NO. 4616 Reisterstown Rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Virgie M. (nee Donnelly)

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1889.

7 AGE	Years	Months	Days 22	If LESS than 1 day, ... hrs. or ..... min.
	40	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamin F. Pierpoint

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rosina Bury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Benj. F. Pierpoint,
(Address) 4616 Reisterstown Rd.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 6, 1930, that I last saw him alive on March 6, 1930, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cholicystitis

"for a few years"
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Gastric dilitation 1 day
Shock (delayed) 2 day
(duration) ..... yrs. ..... mos.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of March 3/30

Was there an autopsy? No

What test confirmed diagnosis? History + clinical findings + operation

(Signed) G. Shipman, M. D.

3-6-, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL 3/8/30 19

UNDERTAKER Harry N. Mitzke ADDRESS 401 Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 7 - 1930 P. M.

Spec.—1-30—M. & T.—250 Blks.

E 54783 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-901 E 54783

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 415 S. Gilmor St. (St.) 19-28 (Ward)

2-FULL NAME Mary E. Mack

(a) RESIDENCE NO. 415 S. Gilmor St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Mack

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Gaas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Sophia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. John H. Mack, 415 S. Gilmor St.
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4/30

17 I HEREBY CERTIFY, That I attended deceased from 3/1/, 1930, to 3/4/, 1930, that I last saw h-w alive on 3/4/30, 19....., and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

*Hypertension

(duration) — yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemiplegia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Bernard J. Carey, M. D.

3/6/1930 (Address) 910 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 3/8/30

20 UNDERTAKER Harry T. Nuttle, 4101 Edmondson Ave. ADDRESS

THOMAS H. JOHNS, M. D.

TION is very important. See instructions on back of certificate.

ORT 1930

Spec.—1-30—M. & T.—250 Blks.

Dr Steffler 1319 Light St So 05-6 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

9 to 10 a.m. 1 to 2 P.M. 31

E 54784

CERTIFICATE OF DEATH.

E 54784

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S. Carrollton Ave St.) 18-29 (Ward)

2-FULL NAME Todd N. Kunkel

(a) RESIDENCE NO. 112 S Carrollton Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/29/78

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
51	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer U. S. A.

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James S. Kunkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Nancy Kosar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Nancy E. Kunkel

(Address) 112 S. Carrollton Ave

Filed MAR 7 - 1930 WILLIAM J. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/5/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Mar 5, 1930, that I last saw h. in alive on Mar 4, 1930, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Same (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy

(Signed) Wm E Steffler, M. D.

3/7, 1930 (Address) 1319 Light St.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL 3/7/1930

20 UNDERTAKER Wm Cook

ADDRESS 127 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

E 54785

CERTIFICATE OF DEATH

E 54785

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Kenwood Ave ST., 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph W. B Schroeder

(a) RESIDENCE NO. 5 N Kenwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10 1930

7 AGE: Years | Months | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Henry M. Schroeder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Dorothy E. Forkenbrock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr Henry M. Schroeder

(Address) No 5 N Kenwood Ave

15 Filed MAR 7 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY: That I attended deceased from Feb-27, 1930, to March 6, 1930, that I last saw h[illegible] alive on March 6, 1930 and that death occurred, on the date stated above, at 6.05 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease (Patent Foramen ovale)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 14 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Basil J Levington, M. D.

(Address) 1100 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL March 8 1930

20 UNDERTAKER Henry Hoech Son Inc. ADDRESS 1301 E Eager St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54786

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54786

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 715 Belgian Ave ST. 10-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter Unkelbach

(a) RESIDENCE NO. 7121 N. Central Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if foreign born? 58 yrs.) mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced, HUSBAND of (or WIFE of): Dora Unkelbach

6 DATE OF BIRTH (month, day, and year): July 22 1858

7 AGE: Years 71 | Months 7 | Days 13 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs N. Kuhlemann

(Address) 1400 E Biddle St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): MAR -5 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to Mar 5, 1930, that I last saw him alive on Mar 5, 1930, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Jacob Frahm, M. D.

3/6, 1930 (Address) 1823 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: March 10, 1930

20 UNDERTAKER: Henry Hoen's Sons, Inc. — ADDRESS: 130 E Eager St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

233 & 58 E 54787 — 49 ✓ E 54787

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabelle de Coello

(a) RESIDENCE NO. Guayaquil, Equador ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Carlos de Coello

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of indastry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Equador

PARENTS

10 NAME OF FATHER Rafael Valdez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Equador

12 MAIDEN NAME OF MOTHER Octavia Concha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Equador

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 7 - 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6/1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1930, to March 6, 1930, that I last saw her alive on March 6, 1930 and that death occurred, on the date stated above, at 9 35 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Lungs

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? yes - Partial

What test confirmed diagnosis? Gennade laboratory

(Signed) R. Draper Lunt, M. D.

March 6 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ecuador S. A. Mch 10 1930

DATE OF BURIAL

20 UNDERTAKER John O. Mitchell & Son

ADDRESS Place

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54788 | 166 | E 54788

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St., 7-13 Ward)

2-FULL NAME Israel Frielander

(a) RESIDENCE NO. 245 W. 107th St., New York City St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. about mos. 1 da. 9 How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tillie Frielander

6 DATE OF BIRTH (month, day, and year) June 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	35	8-9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mgr Millinery
(b) General nature of industry, business, or establishment in which employed (or employer) Millinery
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Morris Frielander

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Klein

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Dr. N. E. Sinsky (Bro-in-l
(Address) 1047 W. North Ave

15 Filed MAR 7 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride Mercury Poisoning
(Suicide)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Probably Biltmore Hotel

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital Report

(Signed) J. H. Bolen, M. D.

3/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Sholom

DATE OF BURIAL 3/7 1930

20 UNDERTAKER Jack Levin

ADDRESS 1439 E. Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54789 90 E 54789

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

City of Baltimore: (No. St. Joesph Hosp. St. 16-37 Ward)

2-FULL NAME Rosa Sweitzer

(a) RESIDENCE NO. 350[illegible] Bank St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas. Sweitzer

6 DATE OF BIRTH (month, day, and year) Oct. 29/1866

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	63	4	7 6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER -----Seifert

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Amelia L. Sweitzer
(Address) 350[illegible] Bank ST.

Filed MAR 7 - 1930 E. HAMPSON JONES, Registrar
By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 5/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Insufficiency
Hypertension -Arteriosclerosis
(Fell on Raspe Ave nr Belair Rd

(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death? at home?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) [signature], M. D.
3/6/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Oak Lawn Cem.

DATE OF BURIAL Mar 8 1930

20 UNDERTAKER Philips & Herwig

ADDRESS 2016 Orleans

IMPORTANT: Physician is required by law to fill out this certificate of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54790 — 74-001 — E 54790

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 N. Gay St. St. 8-17 Ward)

2-FULL NAME Chas. W. Bates

(a) RESIDENCE NO. 1511 N. Wolfe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... da. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia T. Bates

6 DATE OF BIRTH (month, day, and year) Jan 10/1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	60	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 06

(b) General nature of industry, business, or establishment in which employed (or employer) Water Dept.

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas W. Bates

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Gourley

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Julia T. Bates
(Address) 1129 N. Gay St

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5/30

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1929, to Mar 5, 1930, that I last saw h[illegible] alive on Mar 5, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Endocard[itis]
Cerebral Hemorrhage

(duration) ? yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 3 da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Typical

(Signed) J. W. Bates, M. D.

Apr. 19 30 (Address) 1278 Mc Mechen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL Mar 8 19 30

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

TION is very important. See instructions on back of certificate.

ART [illegible] 1930 [illegible] M. D.

Spec.—1-30—M. & T.—250 Blks.

E 54791 HEALTH DEPARTMENT—CITY OF BALTIMORE 99-001 E 54791

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 N. Rose St (St.) 6-19 (Ward)

2-FULL NAME John A. Smith

(a) RESIDENCE NO. 3 N. Rose St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 13 1883

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	5	21 22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Box Maker
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS
10 NAME OF FATHER Albert Smith
11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)
12 MAIDEN NAME OF MOTHER Catherine Downey
13 BIRTHPLACE OF MOTHER (city or town) Canada
(State or country)

14 Informant Mrs Dora Kellbeck
(Address) 27 N. Belnad Ave

15 Filed ....., 19 ..... Registrar

E. PENDLETON JONES, M. D.

MAR 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1930, to Mar. 5, 1930,
that I last saw h.. alive on Mar. 5, 1930,
and that death occurred, on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Dilatation Heart.
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) Gustav C. Thieme M.D.
, 19 (Address) 16 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Mar 8 1930
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Oldenwald

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54792

CERTIFICATE OF DEATH.

101-001

E 54792

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Orleans ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma B. Boone

(a) RESIDENCE No. 1734 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel B. Boone

6 DATE OF BIRTH (month, day, and year) Sept 8/1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	63	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jessie Lancaster

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Martha Elliot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Daniel B. Boone

(Address) 1734 Orleans St

15 Filed ... C. HAMILTON JONES, M. D. Registrar

MAR 7 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 4/30

17 I HEREBY CERTIFY, that I attended deceased from Mar 4, 1930 to Mar 4, 1930

that I last saw h... alive on Mar 4, 1930

and that death occurred on the date stated above, at 3 45P m.

The CAUSE OF DEATH was as follows:

Cerebral Embolism

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Richardson, M. D.

Mar 7 1930 (Address) 1118 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL Mar 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

TION is very important. See instructions on back of certificate.

Cor.—10-10-28—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54793

101-001

E 54793

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1018 N Mount St., 16-22 Ward)

2-FULL NAME Lorice Lattimore

(a) RESIDENCE NO. 1018 N Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 3 1929

7 AGE: Years | Months: 6 | Days: 3 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none old
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER: Fred Lattimore

11 BIRTHPLACE OF FATHER (city or town): Baltimore,
(State or country)

12 MAIDEN NAME OF MOTHER: Ella Wright

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country)

14 Informant: Ella Lattimore
(Address): 1018 N. Mount

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6 192 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) ..... M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: Mar 7 1930

UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Pennsylvania

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C61-L20M

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54794 24-001 E 54794

CERTIFICATE OF DEATH

REGISTERED NO. 10-14

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. WARD)

2—FULL NAME George W. Chamberlain

(a) RESIDENCE NO. Preston & Valley ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 27 March 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nav. Sol

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Ferdinand Chamberlain

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley St

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1930, to Mar 6, 1930, that I last saw h... alive on Mar 5, 1930 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia,

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed) D. Bernstein M. D.

3/6/30 (Address) 1216 Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar 8 1930

20 UNDERTAKER D. Rita Riedefeld — ADDRESS 914 Fremont Ave

Important. See instructions on back of certificate.

MAR 7 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 54795 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54795

100-001

CERTIFICATE OF DEATH

REGISTERED NO. 24-33

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1017 Williams ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adeladie M Pramschufer

(a) RESIDENCE NO. 1017 William ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 21/928

7 AGE	Years	Months	Days 15	If LESS than 1 day, hrs. or min.
	1	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William A Pramschufer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Viola M Sparks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mr William A Pramschufer

(Address) 1017 William st

Filed MAR 7 - 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6/930

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 1930, to March 6 1930,

that I last saw her alive on March 6 1930

and that death occurred, on the date stated above, at 5= P m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumonia

(doration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) - Bronchitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Mitchell M. D.

3/7 1930 (Address) 1079 William st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemy DATE OF BURIAL Mar 10 1930

20 UNDERTAKER John F Denny ADDRESS 915 Light St

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54796 — 129 E 54796

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 150 East St. St. 5-8 Ward)

2-FULL NAME Mary F. Benson. (C)

(a) RESIDENCE NO. 150 East St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Benson. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
About 50				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Susie Powell. (C) cousin.
(Address) 823 Linden Ave.

15 Filed C. HARRISON JONES, M. D. Registrar

R 7 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5th. 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? no. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto Steinhard, M. D.
3/6. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Glen — DATE OF BURIAL 3-9 1930

20 UNDERTAKER Jas. M. Skinner — ADDRESS 622 E. Eag

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54797 — 109 — E 54797

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5214 Belair Road WARD 26-41

2-FULL NAME Henry Hoey

(a) RESIDENCE NO. 5214 Belair Road ST., ... WARD .....

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice L. Hoey

6 DATE OF BIRTH (month, day, and year) Jan 3rd 1844

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
86	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer ok

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Ellen Clooney

(Address) 5214 Belair Rd.

15 Filed MAR 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1929, to March 6, 1930

that I last saw him alive on March 6, 1930

and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Abscess of throat

old age

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) old age

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Chas D Carey M. D.

, 19 (Address) Carey & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Biddison Family Amity — DATE OF BURIAL March 9 1930

20 UNDERTAKER Frederick Lessard & Son — ADDRESS Fulton

HON IS VERY important. See instructions on back of Certificate

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54798

CERTIFICATE OF DEATH

143-001

E 54798

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 26-42 Ward)

2-FULL NAME NELLIE DeBAUGH

(a) RESIDENCE NO. 5810 Radecke Ave. St., Ward

(Usual place of abode) Baltimore (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jessie L. DeBaugh

6 DATE OF BIRTH (month, day, and year) February 2nd, 1890.

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	40	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 097
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town) Kansas
(State or country)

PARENTS

10 NAME OF FATHER Rulendus Pitts

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Nellie Shea

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant Jessie DeBaugh
(Address) 5810 Radecke Ave.

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure-Myocarditis
Peritonitis-Infected Abortion
(History self induced.)

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. 10 ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History at Hospital

(Signed) [signature] M. D.

3/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Mar. 9, 19 30
20 UNDERTAKER	ADDRESS
Frederick Lawrence Co.	Fullerton.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54799 E 54799

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 519 S. Brunswick ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.) 20-69 (WARD)

2—FULL NAME Dietrich Meyer

(a) RESIDENCE NO. 519 S Brunswick ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elise Meyer

6 DATE OF BIRTH (month, day, and year) Aug 4 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
76	77	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lisse Germany

PARENTS

10 NAME OF FATHER Henry Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lisse Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wilhelm Johansson
(Address) 519 S Brunswick St

15 Filed 3-7-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-6-30

17 I HEREBY CERTIFY, That I attended deceased from February 25, 1930, to March 6, 1930, that I last saw him alive on March 5, 1930 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Mitral Insufficiency)
Lobar Pneumonia, Cl.
Extensive Nephritis
(duration) ...

CONTRIBUTORY (Secondary) Coronary Thrombosis
(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) Robert C Riker, M. D.

3/6, 1930 (Address) 2157 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 3/10 1930

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54800

CERTIFICATE OF DEATH

91-002 E 54800

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Delaney

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Flavitt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Mills

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk.

14 Informant Little Sisters of the Poor

(Address) Preston & Valley St

15 3-7-1930, 10 C. HAMPSON GANTS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Mar 6, 1930.

that I last saw h[illegible] alive on Mar 6, 1930

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Clement Watts M. D.

3/7, 1930 (Address) 1164 Colvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Mar. 8, 1930
20 UNDERTAKER	ADDRESS
Rita Winfield	914 Greenmount Ave

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 34563 E 34801

CERTIFICATE OF DEATH

109-002 51801

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joan Wells

(a) RESIDENCE NO. 516 Greenlawn Rd ST. WARD Towson Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 5 ds. How long in U. S., if foreign birth? 10 yrs. 4 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct-12-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer none Bethlehem

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER John B Wells

11 BIRTHPLACE OF FATHER (city or town) Newton (State or country) Mass.

12 MAIDEN NAME OF MOTHER Adelaide Reardon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

MAR 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7-1930

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 7, 1930, that I last saw her alive on March 7, 1930 and that death occurred, on the date stated above, at 7 20 a. m.

The CAUSE OF DEATH* was as follows:

Septicemia from cellulitis of throat -

Myocardial insufficiency

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of March 4, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) F. C Grove, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 3/8/1930

20 UNDERTAKER Stewart & Co

ADDRESS Baltimore Md.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54802 57 E 54802

CERTIFICATE OF DEATH

REGISTERED NO. 57

1—PLACE OF DEATH Md General Hosp

CITY OF BALTIMORE: (No. Howard + Madison ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lunzio Pierantozzi

(a) RESIDENCE NO. 1736 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Peter Pierantozzi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Loretta Leonda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hosp Record

(Address)

15 Filed ..... 19 ..... Registrar

R 7-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1930, to March 6, 1930, that I last saw him alive on March 6, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Fibrillar Gangrene

Idiopathic Gangrene

March 9 1930

(duration) yrs. mos. 70 ds.

CONTRIBUTORY (but not related to cause given) Cerebral Embolism

(duration) yrs. mos. 1 da.

Where did disease contract
Duration of place of death?

Did operation precede death? Yes Date of Jan 20 + Feb 20

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab.

(Signed) H. E. Kupelmeister, M. D.

March 6 1930 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	March 8 1930
20 UNDERTAKER John Ulrich	ADDRESS 2008 Eastern

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54803

CERTIFICATE OF DEATH

74001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1350 N. Calhoun St. 15-22 (Ward)

2-FULL NAME Mary Blackburn Blackwell

(a) RESIDENCE NO. 1350 N. Calhoun St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Md.

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mary Strand
(Address) 1136 Brewer St

15 March 7 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy) (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) C. H. Jones, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 3-8 1930

20 UNDERTAKER Daniel Easton

ADDRESS 916 De ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 7 - 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54304

E 54304

CERTIFICATE OF DEATH

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1035 W. Lexington St. 18-76 Ward)

2-FULL NAME Zachariah White

(a) RESIDENCE NO. 1039 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary White

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Zachariah White

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Lottie White

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary White
(Address) 1039 W Lexington

15 MAR 7 1930 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brownley M. D.

3/7 1930 (Address) 3601 3-Fr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Church Cem

DATE OF BURIAL 3-8 1930

20 UNDERTAKER David Carlson

ADDRESS 946 E. Fr.

IMPORTANT: Before signing, make sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54305

CERTIFICATE OF DEATH

113 E 54305

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1328 McCulloh St. 11-24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Hunter

(a) RESIDENCE NO. 1328 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day and year): Sept 13-1929

7 AGE: Years 10 | Months 9 | Days 23 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Boy
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Balto

9 BIRTHPLACE (city or town): Balto
(State or country)

PARENTS

10 NAME OF FATHER: Alfred Hunter

11 BIRTHPLACE OF FATHER (city or town): N C
(State or country)

12 MAIDEN NAME OF MOTHER: Maggie Sessoms

13 BIRTHPLACE OF MOTHER (city or town): N C
(State or country)

14 Informant: Maggie Hunter
(Address): 1328 McCulloh

15 Filed ....., 19..... C. HAMPSON JONES, M.D. Registrar

R 7-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) ..... M. D.

(Address) ..... Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 3-8 1930

20 UNDERTAKER: Daniel Easter & Co

ADDRESS 916

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54806 ✓ 45 E 54806

CERTIFICATE OF DEATH

E 54806

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 Penna. Ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Smackum

(a) RESIDENCE NO. 1902 Pennsylvania Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	married

5a If married, widowed, or divorced (or) WIFE of Chas. Smackum

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Charles Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Smithmoor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Smackum

(Address) 1702 Penna ave

15 Filed 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1930, to March 6, 1930, that I last saw h[illegible] alive on March 4, 1930 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Pentoneal Carcinomata

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. M. Ward, M. D.

3/7, 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 3-8 1930

20 UNDERTAKER Daniel Easter

ADDRESS 916 Pa ave

IMPORTANT: See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54807 43 E 54807

CERTIFICATE OF DEATH

1—PLACE OF DEATH Church Home & Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Schreck

(a) RESIDENCE NO. 723 N. Curley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Schreck

6 DATE OF BIRTH (month, day, and year) July 6, 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
69	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER — Schreck

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Simpson
(Address) 723 N. Curley

15 Filed MAR 7 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 5 1930, that I last saw him alive on March 5, 1930 and that death occurred, on the date stated above, at 5 50 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/4/30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Irving B. Wallace M. D.

, 19 (Address) Church Home & Infir.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Mar. 8 1930

20 UNDERTAKER C. Miller & Son

ADDRESS 2334 Jefferson Ave

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54808

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ 54808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 26-37 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tony Papa

(a) RESIDENCE NO. 1105 Keen Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Michal Papa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3-30

17 I HEREBY CERTIFY, That I attended deceased from 3-2-30, 19 ..... to 3-3-30, 19 .....

that I last saw him alive on 3-3-30, 19 .....

and that death occurred, on the date stated above, at 6 A. M. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

3-3, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL March 5, 19 30

20 UNDERTAKER Mendell J. Appel

ADDRESS 300 S. Colum

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54809 — 90 — E 54809

1-PLACE OF DEATH

City of Baltimore: (No. 2301 Tucker Ave. Ward 28-65)

REGISTERED NO. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Doody

(a) RESIDENCE NO. 2301 Tucker Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta

6 DATE OF BIRTH (month, day and year) July 11 1862

7 AGE	Years	Months	Days	IF LESS than 1 day..... hrs. or..... min.
	67	7	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER John Doody

11 BIRTHPLACE OF FATHER (city Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Penney

13 BIRTHPLACE OF MOTHER (city Ireland
(State or country)

14 Informant Margaret Duggan
(Address) 1203 [illegible]

15 Filed ..... 19.. C. HAMPSON JONES, Registrar
MAR 8 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. B. Leech M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cemetery	Mar 8 1930
20 UNDERTAKER John F. Denny	ADDRESS 715 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

28 — 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54810 99-002 E 54810

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-63

CITY OF BALTIMORE: (No. 4100 Ridgewood Av ST.) (15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lodowic Jefferson Milbourne

(a) RESIDENCE NO. 4100 Ridgewood Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret E. Milbourne

6 DATE OF BIRTH (month, day, and year): Sept 21 1846

7 AGE: Years 83 | Months 5 | Days 13 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Advertising Agent

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Shelltown Md

PARENTS

10 NAME OF FATHER: Frank Milbourne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Araminta Milbourne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Katherine M. Milbourne
(Address): 4100 Ridgewood Ave

15 Filed MAR 28 1930 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 6-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Mar 6, 1930, that I last saw him alive on Mar 6, 1930, and that death occurred, on the date stated above, at 4:20 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral recurrent hemorrhage with resultant confusion

(duration) — yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & Symp.

(Signed) Wesley Culp, M. D.

3/6, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Mar 8 1930

20 UNDERTAKER: John A. Denny — ADDRESS: 7 S Light St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54811

CERTIFICATE OF DEATH

74-001 E 54811

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 133 E Clement ST. 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maggie Forsythe

(a) RESIDENCE NO. 133 E Clement ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) March 28 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert T Forsythe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Harriet A Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Mary A Smith

(Address) 133 E Clement St

15 Filed 8 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I attended deceased from March 27 1930, to March 6 1930

that I last saw h[illegible] alive on March 6 1930

and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension undef

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L A Rhoades M.D.

March 7 1930 (Address) 112 N. Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Olivet — DATE OF BURIAL March 8 1930

20 UNDERTAKER John F Penny — ADDRESS 715 E 25 St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54812 — 31 — E 54812

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) 2041 E. Eager ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A Orr

(a) RESIDENCE NO. 2041 E. Eager ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign-birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C Orr

6 DATE OF BIRTH (month, day, and year) Oct 5 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence Orr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs James F Orr
(Address) 2041 E Eager st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1930, to March 6, 1930,

that I last saw h alive on 19

and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pneumonia

(duration) yrs mos 14 ds.

CONTRIBUTORY (Secondary) Myocardial Fibrosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ralph Fahrney, M. D.

19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL March 10 1930

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

MAR 8 1930

ASK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO. 54813

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3114 Barclay ST. 12-50 WARD)

2-FULL NAME Louis Wm Nancy.

(a) RESIDENCE NO. 3114 Barclay ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 60 mos. 6 yrs ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mal

4 COLOR OR RACE Col.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Nancy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	about 70			

8 OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work Nursery Man

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mary Nancy (Address) 3114 Barclay St.

15 Date 8-1930 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1930, to March 6, 1930, that I last saw him alive on March 4, 1930, and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) High Blood Pressure Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of work,

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Nancy, M. D.

, 19 (Address) 1215 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Auburn Cemetery Mar. 9 1930

20 UNDERTAKER — ADDRESS

Chas. N. Johnson 406 N. Caroline St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 54814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74-91 E 54814

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 934 N. Gilmor St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susanna E. Miller

(a) Residence No. 934 N. Gilmor St., Ward 16.

(Usual place of abode)

Length of residence in city or town where death occurred 9 weeks yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col.

5-Single, Married, Widowed, or Divorced, (Write the word) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) unknown

7-AGE. 66 yrs. 2 mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, William Burton

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Delaware

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) George Glasco

(Address) 934 N Gilmor St.

15- Filed 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-6-30

17- I HEREBY CERTIFY, That I attended deceased from March 2nd, 1930 to March 6th, 1930.

that I last saw her alive on March 6th, 1930,

and that death occurred, on the date stated above, at 1.42 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. M. Lawrence M. D.

, 19 (Address) 1232 Brooks Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. West Chester Pa

DATE OF BURIAL. 3-9-30

20-UNDERTAKER, John H. Joachim and Sons

ADDRESS 1027

In plain terms, so that it may be properly classified. See instructions on back of certificates.

R 8

Spec.—1-30—M. & T.—250 Blks.

E 54815 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54815

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. ..... ST. 17-25 WARD)

2-FULL NAME Frank Fallin

(a) RESIDENCE NO. 658 W. Franklin st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Alfred Fallin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER May Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed ..... 19 .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 19 29, to March 6, 19 30, that I last saw him alive on March 6, 19 30, and that death occurred, on the date stated above, at 10.55 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Tuberculous pleuritis

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas Garnett M. D.

3-7-19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Mar 8 1930

20 UNDERTAKER Samuel Bowers

ADDRESS 700 W. Lanvale ave.

R 8 - 1930 C. W. SING, HOSP.

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 54316

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54316

43

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Sarah Ann St. 4-27 WARD)

2-FULL NAME Nurses Stewart

(a) RESIDENCE NO. 1617 Sarah Ann ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred abt 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Stewart

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
abt 60 +				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) (State or country) St Mary's Co Md

PARENTS

10 NAME OF FATHER John Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co Md

12 MAIDEN NAME OF MOTHER Maud Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Richard Stewart, (Son)
(Address) 1909 Ann St

Filed APR 8 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1930, to March 5, 1930, that I last saw h[illegible] alive on March 25, 1930 and that death occurred, on the date stated above, at 4 P m

The CAUSE OF DEATH* was as follows:

Carcinoma
Chest Right

abt 6 mos (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted abt if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

, 19 (Address) 1626 W Fay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem DATE OF BURIAL March 8 1930

20 UNDERTAKER C. Jones ADDRESS 1112 Eden

CAUSE OF DEATH must be given in plain terms. See instructions on back of certificates. TION is very important

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54817 — 101 — 001 — E 54817

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1601 Mosher ST. 16-2 WARD)

2-FULL NAME Janie Talbert

(a) RESIDENCE NO. 1601 Mosher ST, WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Talbert

6 DATE OF BIRTH (month, day, and year) Mar.4,1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min
	48		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chestertown, Md.

PARENTS

10 NAME OF FATHER Isaac Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chestertown Md.

12 MAIDEN NAME OF MOTHER Liza Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cheatertown Md.

14 Informant (Address) Howard Talbert 1601 Mosher St.

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar.7 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar.2 , 1930 , to Mar 7, , 19 30.

that I last saw her alive on Mar.6 , 19 30

and that death occurred, on the date stated above, at 3;10a.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Bi-lateral

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1631 E. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn Cem Md

UNDERTAKER E. Jones

DATE OF BURIAL 10th 19 3

ADDRESS 111 S. Gilmor

CAUSE OF DEATH to be given in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

8 — 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54818

101-001 54818

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH University Hospital 13-54 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2—FULL NAME Laura Jennings

(a) RESIDENCE NO. 2304 E Eting Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if [redacted] yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anderson

6 DATE OF BIRTH (month, day, and year) Unknown 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER Warren Epps

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Isabella Smith

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant Wm. Jennings

(Address) 2304 Etting Street

15 Filed ..... 19 ..... Registrar

HAMILTON JONES, M.

APR 8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6th

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1930, to March 6th, 1930

that I last saw h[illegible] alive on March 6th, 1930

and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Heart failure congestive with congestion of liver and general anasarca (duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar pneumonia, left lower lobe (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Louis J. Gundry M. D.

March 6 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crem Va — DATE OF BURIAL Mar 8, 1930

20 UNDERTAKER Mrs. Ida Snowden — ADDRESS 1708 G Madison st.

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54819 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54819

CERTIFICATE OF DEATH.

1-001 ✓ 101 15-65

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2408 Chelsea Terrace WARD)

2-FULL NAME Sara Nuvill Chase Shriver

(a) RESIDENCE NO. 2408 Chelsea Terrace ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonidas Shriver

6 DATE OF BIRTH (month, day, and year) Sept 10 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hannibal Case

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Rebecca Nuvill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Mrs. Shriver (Address) 2408 Chelsea Terrace

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7-1930

17 I HEREBY CERTIFY, That I attended deceased from March 1 1930, to March 7, 1930, that I last saw her alive on March 7, 1930, and that death occurred, on the date stated above, at 7.17 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Toxemia 7

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? None Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Sputum - Type 3

(Signed) Edwin R Ballard M. D.

3/8. 1930 (Address) 1622 Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem

DATE OF BURIAL March 10 1930

UNDERTAKER John O Mitchell Sons

ADDRESS 1900 Eutaw Place

TION IS very important. See instructions on back of certificate.

3-28-1930

Spec.—2-29-28—L. F. S.—500 Blks.

Edith List

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54820 — 129 ✓ — E 54820

CERTIFICATE OF DEATH

1—PLACE OF DEATH South Baltimore Gen Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Edith List

(a) RESIDENCE NO. 1827 S. Charles ST., ... WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

6a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Frank H. List

6 DATE OF BIRTH (month, day, and year) 12/10/1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Geo Griffiths

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Ann Jenks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Frank A. List

(Address) 1827 S. Charles st

15 Filed ..... 19 .....

APR 8 - 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7-30

17 I HEREBY CERTIFY, That I attended deceased from 1-8, 1930, to 3-7, 1930

that I last saw her alive on 3-7, 1930

and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Hypertension

Chronic Myocarditis (duration) 4 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Joseph B. Lankaitis, M. D.

, 19 (Address) South Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 3/10/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Important. See instructions on back of certificate.

Spec.—2-29-28—1z. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54821

CERTIFICATE OF DEATH

100-001

E 54821

REGISTERED NO. 27-63

1—PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 40th & Cedar Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen M. Stewart

(a) RESIDENCE NO. 708 Wyndhurst Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced (or) WIFE of George G. Stewart

6 DATE OF BIRTH (month, day, and year) June 6, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pennsylvania

PARENTS

10 NAME OF FATHER Robert Hodge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Hannah Elizabeth Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Minnie McM Crawford

(Address) 708 Wyndhurst Ave

15 Filed , 19 Registrar

8-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1930, to March 6, 1930, that I last saw her alive on March 6, 1930 and that death occurred, on the date stated above, at {4.30 P. m. 3/7/30

The CAUSE OF DEATH* was as follows:

Senile arteriosclerosis

(duration) Many yrs. mos. ds.

CONTRIBUTORY (Secondary) bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? H.S.

(Signed) H. S. Willis, M. D.

19 (Address) Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 3/8/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54822

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54822

31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.) ST., 36-42 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Alice Smith

(a) RESIDENCE NO. 4506 Parkmont ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Smith

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 37

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John E. Monroe

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susie Boston

13 BIRTHPLACE OF MOTHER (city or town) Maryland

(State or country)

14 Informant Hospital Records

(Address)

15 Filed ..... 1930 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 5, 1929, to March 7, 1930,

that I last saw her alive on March 7, 1930,

and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Shumoel Jr. M. D.

3-7, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 3/10/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 90 E 54823

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 510 N Arlington St., (or WARD) 16-2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arline Reese Reaver

(a) RESIDENCE NO. 510 N. Arlington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 8 mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 ~~Single, Married~~, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charlton Reaver

6 DATE OF BIRTH (month, day, and year): Aug 3-1846

7 AGE — Years: 83 | Months: 7 | Days: 4 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Frederick Co. Md

PARENTS

10 NAME OF FATHER: Richard Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Catherine Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm E Ferguson

(Address) 3015 Ennison Blvd

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

R 8 — 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1924, to Mch 7th 1930, that I last saw h[illegible] alive on Mch 7 1930 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 1 yrs. 3 mos. ... da.

CONTRIBUTORY (Secondary): Cardiac Failure (duration) ... yrs. mos. 20 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert L. Kirk, M. D.

3/8, 1930 (Address) 326 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middletown Frederick Co Md

DATE OF BURIAL: Mar 9th 1930

20 UNDERTAKER: Putman & Gore

ADDRESS: 1123 W Lafayette Ave

important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54824 44 E 54824

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1315 N Mount (St.) 15-23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore R. Gamble

(a) RESIDENCE NO. 1315 Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs + mos + ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male Female

4 COLOR OR RACE colored

5 Single, Married, Widowed, or Divorced, (write the wurd) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hilda Gamble

6 DATE OF BIRTH (month, day, and year) March 18, 1901

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
29	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Helen Gamble (Address) 1315 Mount St.

15 Filed 3/8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1930, to March 6, 1930, that I last saw h[illegible] alive on March 4, 1930, and that death occurred, on the date stated above, at 3:20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver

(duration) + yrs. 5 mos 7 ds.

CONTRIBUTORY (Secondary) Hemorrhage from erosion of aortic Blood Vessels (duration) yrs. mos. One ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical, microscopic

(Signed) Charles E. Cleary, M. D.

3/5 1930 (Address) 3214 Piedmont Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL March 8th 1930

20 UNDERTAKER Thomas E. Kelson ADDRESS 1302 Pressman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54825

REGISTERED NO. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4607 Bayonne Ave St., 27-43 Ward)

2-FULL NAME Mary Vavrina

(a) RESIDENCE NO. 4605 Bayonne Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank J. Vavrina

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER Vaclav Brony

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Zitnik

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Mary Philip
(Address) 900 N. Madeira St

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

R 8 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 5/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wounds in brain
(Homicide)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) ..., M. D.

3-7-30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Mar. 8 1930
20 UNDERTAKER	ADDRESS
Frank Cvach & Son 1906	Ashland Av

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NAME and ADDRESS must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—V&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 V

REGISTERED NO. 54826

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 921 Dulmer 6t ST. 17-23 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Crane

(a) RESIDENCE NO. 921 Dulmer 6t ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND OF~~ or) WIFE of: Joseph Crane

6 DATE OF BIRTH (month, day, and year): April 6 1881

7 AGE: Years 48 Months 11 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Elkton City Md

PARENTS

10 NAME OF FATHER: Jack Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Elkton City Md

12 MAIDEN NAME OF MOTHER: Mary Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Elkton City Md

14 Informant (Address): Gladys Crane 921 Dulmer St

15 Filed 3/7 1930 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 24 1930 to March 6 1930, that I last saw her alive on March 5 1930, and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Valvulitis

Nephritis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) W. F. Roselle M. D.

3/7 1930 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: May 10, 1930

20 UNDERTAKER: Mrs Katie R. Williams

ADDRESS 3227 Schroeder St

TION is very important See instructions on back of certificate

R8 -1930

Cor.—10-10-29—A Co.—100 Bks.

E 54827

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 E 54827

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore & Calvert St. St. 3-4 Ward)

2-FULL NAME James R Thomas.

(a) RESIDENCE NO. 801 S. Bond St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. —mos.— ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~
HUSBAND of (or) WIFE of Mary A. Thomas.

6 DATE OF BIRTH (month, day, and year) April 15, 1868

7 AGE	Years	Months	Days 21	IF LESS than 1 day ...hrs. or ...min.
	61	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance Agent.
(b) General nature of industry, business, or establishment in which employed (or employer) ol
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Lewis Thomas.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER ------ Ferris.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Mary A. Thomas. (wife)
(Address) 2914 Ellicott Drive.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

Rec'd

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Steinhardt, M. D.

3/8, 1930 (Address) 1019 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 3/10/30

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmondson Ave

8

IMPORTANT. Should be carefully supplied. Any error should be noted at once. Particular attention should be given to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54828

CERTIFICATE OF DEATH

118-901

E 54828

REGISTERED NO.

1—PLACE OF DEATH Church Home & Infirmary

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore ST. 12-W WARD)

2—FULL NAME Alphonse Thomas, Sr.

(a) RESIDENCE NO. 3313 St. Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Thomas.

6 DATE OF BIRTH (month, day, and year) Aug 23-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Pierre Thomas.

11 BIRTHPLACE OF FATHER (city or town) Cannes (State or country) France

12 MAIDEN NAME OF MOTHER Elmira Manner

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Chas. Burlander

(Address) 3605 Brantley Road

15 Filed MAR 28 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 4, 19 30, to Mar. 7, 19 30, that I last saw him alive on Mar. 7, 19 30 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency &
Dilated Myocarditis

Bilateral Inguinal Hernias unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Partial Intestinal Obstruction 24 hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/5/30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Erwin B. Wallace M. D.

, 19 (Address) Church Home & Infir

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL Mar. 10 1930

20 UNDERTAKER Wm. J. Hickner Sons

ADDRESS North Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54829

CERTIFICATE OF DEATH

74 1001 E 54829

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3400 Grantley Road St. 15-62 Ward)

2-FULL NAME Marian Estelle Robertson

(a) RESIDENCE NO. 3400 Grantley Road. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 5 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Dr. J. Clagett Robertson

6 DATE OF BIRTH (month, day, and year) September 15th 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	48	5	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(r) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter H. Grappel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Schaufelberger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Dr J. Clagett Robertson
(Address) 3400 Grantley Road.

15 Filed ..., 19... Registrar

MAR 8 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains desrribed above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidenre obtained by said Inquest, autopsy or inquiry) find that said decrased rame to ... on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis (duration) ... yrs. Sudden

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease rontrartrd If not at plare of death? Home

Did an operation prerede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) ... M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Mar 10 1930

20 UNDERTAKER: Wm J Tichnor & Sons — ADDRESS: Notaker

This should be carefully supplied. Age should be given in years, months and days if under one year. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54330 — 31

REGISTERED NO. E 54330

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 242 S Chester ST., 7-4 WARD)

2—FULL NAME August Steube

(a) RESIDENCE NO. 242 So. Chester ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 4 mos. 9 ds. How long in U. S., if foreign birth? 38 yrs. 4 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Steube

6 DATE OF BIRTH (month, day, and year) Oct 27, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	63	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stable Boss

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Steube

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Anna Steube

(Address) 242 So Castle St.

15 Filed MAR 8 1930 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4th, 1930, to March 8th, 1930, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 9.05 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) I. Krumm J. Guerus, M. D.

March 6, 1930 (Address) 1906 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Immanuel Cem.

DATE OF BURIAL 3-10 1930

ADDRESS 32 S. Broad

UNDERTAKER Louis J Seemann

ADDRESS 32 S. Broad

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54831

CERTIFICATE OF DEATH

129 ✓

E 54831

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 22-50 WARD)

2—FULL NAME William Purdy Draper

(a) RESIDENCE NO. 2713 St. Paul ST., WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
mal	Wht	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lora Anna Draper

6 DATE OF BIRTH (month, day, and year) July 4 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
52	51	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer Self Employed

9 BIRTHPLACE (city or town) Brooklyn (State or country) N.Y.

PARENTS

10 NAME OF FATHER James Bateman Draper

11 BIRTHPLACE OF FATHER (city or town) Delaware (State or country)

12 MAIDEN NAME OF MOTHER Rosanna Corby

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs Lora A Draper

(Address) 2713 St Paul Ste

15 Filed MAR 8 1930 C. HAMPSON JONES, M. D. Registrar

By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930. to March 8, 1930

that I last saw h~~e~~ alive on March 8, 1930

and that death occurred, on the date stated above, at 11 30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, hypertension

Bronchopneumonia, uremia.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) W. H. Varney, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Denton Md

DATE OF BURIAL March 8 1930

20 UNDERTAKER John O. Mitchell & Sons

ADDRESS 1900 Eutaw Place

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54832

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54832

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 N. Calhoun St., 14-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia E. Wyche

(a) RESIDENCE NO. 513 N. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wyche

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Petersburg Va

(State or country)

PARENTS

10 NAME OF FATHER John H. Lee

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Martha Royal

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant John Wyche

(Address) 513 N. Calhoun St

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 / 30

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1930, to May 6, 1930

that I last saw h.. alive on May 6, 1930

and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) 2 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. T. Fletcher, M. D.

3/8, 1930 (Address) 1225 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va — DATE OF BURIAL 3/8 19 30

20 UNDERTAKER Samuel I. Stewart — ADDRESS 578 Cable

TION is very important. See instructions on back of certificate

C. HARRISON JONES, M.

MAR 9 - 1930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54833 E 54833

CERTIFICATE OF DEATH.

74-001

REGISTERED NO. 20-69

1-PLACE OF DEATH 2543 McHenry St

CITY OF BALTIMORE: (No. [redacted] ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Ragazinskas (1)

(a) RESIDENCE No. [redacted] 2543 McHenry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Joseph Ragazinskas (1)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Ane Belzate

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Joseph Ragazinskas

(Address) 831 W. Lombard St.

Filed MAR 9 - 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 7, 1930, that I last saw him alive on March 6, 1930, and that death occurred, on the date stated above, at 10:45a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bronushas, M. D.

3-8-1930 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL March 12, 1930

20 UNDERTAKER John Szablinskas

ADDRESS 423 S. Ewen St.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

$4834 ✓ E 51834 E 51834 × 57

REGISTERED NO. .....

1-PLACE OF DEATH West Baltimore Gen'l Hosp (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Baltimore Md S. 16-68 WARD)

2-FULL NAME John Merryman

(a) RESIDENCE NO. Old Frederick Rd ST., WARD Catonsville

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day..... hrs or..... min.
67		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co - Md

PARENTS

10 NAME OF FATHER Chas Wm Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosa Berry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs E. M. Foreman (Address) 2223 Mt Holly

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/25/30, 19..., to 3/8/30, 19...

that I last saw h alive on 3/8/30, 19... at 6 P m

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Gangrene

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Diabetes mellitus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) D. A. Pearce, M. D.

, 19 (Address) West Balto Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem DATE OF BURIAL May 11 1930

20 UNDERTAKER Easton Sons ADDRESS Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information of cause of death is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54835 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 54835

CERTIFICATE OF DEATH + 153

REGISTERED NO.

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 4-30 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Annie L Means

(a) RESIDENCE NO. Westminster Pike ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. H Means

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 027

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Gentz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Starner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry Bankard

(Address) Westminster Md

15 Filed MAR 9 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9-1930

17

I HEREBY CERTIFY, That I attended deceased from March 5 -, 1930, to March 9 -, 1930, that I last saw her alive on March 9 -, 1930 and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of face

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Staphylococcus septicemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms Laboratory tests

(Signed) Walter B. Johnson, M. D.

3- 9 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster

DATE OF BURIAL 3/11 1930

20 UNDERTAKER H Bankard & Son

ADDRESS Westminster

important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓

E 54836

E 54836

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1343 Jackson ST. (WARD) 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Virginia Wise

(a) RESIDENCE NO. 1343 Jackson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of August Wise

6 DATE OF BIRTH (month, day, and year) Feb, 28 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	--	7 9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Daisy Belle Taylor

(Address) 1343 Jackson St.

15 Filed MAR 9 1930, 19 [illegible] Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb-24, 1930, to March 7, 1930, that I last saw h[illegible] alive on March 7, 1930 and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Acute myocardial failure

immediate (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cleurisy - Bronchopneumonia (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 1224 Stevenson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monumental Wharf Co

DATE OF BURIAL Mar 9 1930

20 UNDERTAKER John A. Denny

ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-001

E 54837

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital ST. 15-66 (WARD).

CITY OF BALTIMORE: (NO.

2-FULL NAME Albert Kerner

(a) RESIDENCE NO. 2214 Baker St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sylvia Kerner

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER David Kerner

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Rodner

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Emanuel Rodner (Address) 1814 or Orleans St

15 Filed MAR 9 - 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1930

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 8, 1930, that I last saw h im alive on March 8, 1930, and that death occurred, on the date stated above, at 8 30 A. m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach (Cardia) Hemorrhage, Intragastric

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary) Ulcer of stomach (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Jno Buyniklos, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Nessing Rus

DATE OF BURIAL 3/11 1930

ADDRESS

20 UNDERTAKER Jack Levin 1439 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 54838

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 54838

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.) Monument ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Craven

(a) RESIDENCE NO. 313 E. Fort Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) in fant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1929

7 AGE Years 0 Months 7 Days 6

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis Craven

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Femmel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Craven

(Address) 313 E Fort ave

15 Filed MAR 8 - 1930 HAMILTON JONES, M. D. By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7 - 1930

17

I HEREBY CERTIFY, That I attended deceased from March 7, 1930, to March 7, 1930, that I last saw her alive on March 7, 1930, and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Circulatory failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) J. H. Conn, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Monument Park DATE OF BURIAL 3/9 1930

20 UNDERTAKER Jack Levin ADDRESS 1439 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54839 188-103 E 54839

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH City of Baltimore: (No. St. Agnes Hospital 43-54 St. .... Ward)

2-FULL NAME Philip Fish

(a) RESIDENCE NO. 2219 Callow Ave. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. .... mos. .... ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Florence Fish

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day .... hrs. or .... min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Collector
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Boris Fish

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Bubey Yasepsky

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Florence Fish (Wife)
(Address) 2219 Callow

15 Filed MAR 9 - 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by moving auto after passing from behind another. Fract Skull (duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary) Cerebral Hem (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? Fulton St

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Frank M. D.

3/9 1930 (Address) 7939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 3/9 1930

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balt St

Information should be carefully supplied. Age should be stated EXACTLY. PHYSICIAN should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54840

CERTIFICATE OF DEATH.

10 1-001 E 54840

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument & Rutland (St.) 15-68 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Dawn

(a) RESIDENCE NO. 2218 Prentiman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Jan 26 1924

7 AGE — Years: 8 Months: 1 Days: 9/11

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto city Md

PARENTS

10 NAME OF FATHER David Doris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Etta S.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Etta P. Doris

(Address) 2218 Prentiman St

15 Filed MAR 9 1930 19 C. HAMPSON JONES, M. D. Registrar

Bur. Plot

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/13, 1930, to 3/7, 1930, that I last saw h[illegible] alive on 3/7, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) ..... yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Several Herpes (duration) ..... yrs. ..... mos. 6 ds. cured

18 Where was disease contracted if not at place of death? Not Apparent

Did an operation precede death? ..... Date of 2/28/30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. E. Goodman, M. D.

3/7, 1930 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Shulmans

DATE OF BURIAL 3/10 1930

20 UNDERTAKER Jack Lewis 1439 E Balto

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Levin

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54841

E 54841

CERTIFICATE OF DEATH.

90

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2034 Linden ave. 11-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Levin

(Residence in Baltimore: No. 2034 Linden ave. St.; 40 yrs. ..... mos. ..... da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widowed

6-DATE OF BIRTH. Unknown (Month) ..... (Day) 1833. (Year)

7-AGE. 97 yrs. ..... mos. ..... da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Hebrew teacher
(b) General nature of industry, business, or establishment in which employed (or employer). 068

9-BIRTHPLACE. (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Levin

(Address) 1439 E. Baltimore St.

15-

Filed ..... 191..... Registrar.

C. HAMPSON JONES, M. D.

MAR 9 - 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 7th, 1930.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 6th 1930, to March 7th 1930, that I saw him alive on March 7th 1930, and that death occurred, on the date stated above, at 8 15 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Cerebral haemorrhage

(Duration) ..... yrs. ..... mos. 2 da.

(Signed) Benjamin Posthumus M. D.

March 8, 1930 (Address) 1807 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Hebrew Hebrew Rest

DATE OF BURIAL. 3-9..., 1930

20-UNDERTAKER Jack Levin 1439

ADDRESS E Balto St

CAUSE OF DEATH to be plainly written in ink and in language understood by all persons. Abbreviations and ditto marks are not important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E54842 HEALTH DEPARTMENT—CITY OF BALTIMORE E54842.

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST. Bay ..... WARD)

2-FULL NAME John Prochowski

(a) RESIDENCE No. 603 S. Dallas ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 40 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Prochowski

6 DATE OF BIRTH (month, day, and year) Oct. 1, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Poland

14 Informant ..... (Address) BALTIMORE CITY HOSPITALS

15 Filed APR 10 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9-30

17 I HEREBY CERTIFY, That I attended deceased from 3-6, 1930, to 3-9, 1930, that I last saw him alive on 3-9, 1930, and that death occurred, on the date stated above, at 7:15 A.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, 2d

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical: Autopsy

(Signed) Marvin M. McLean, M. D.

3-9, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL month 11 1930

20 UNDERTAKER George A. Weber

ADDRESS 705 S. Ann St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54843 — CERTIFICATE OF DEATH — 118-002 ✓ — E 54843

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2104 N. Charles ST. 42-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriet Pollock Heavenfort

(a) RESIDENCE NO. 2104 N. Charles ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F. | 4 COLOR OR RACE: W. | 5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Thos R Heavenfort

6 DATE OF BIRTH (month, day, and year): Jan 15-1847

7 AGE: 83 Years | Months 1 | Days 23 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Georgia Alabama

PARENTS

10 NAME OF FATHER: Josiah Pollock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Mariah Eliz Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Mrs L Dennison (Address) 2104 N Charles St

15 Filed MAR 9 1930 (19) HAMILTON JONES, M. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 8/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 29, 1929, to Mar 8, 1930

that I last saw h.. alive on Mar 8, 1930

and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Senile (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Wm H Pearce M. D.

Mar 8. 1930 (Address) 2105 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Burningham, Jefferson Co Ala	Mar 10 1930
20 UNDERTAKER	ADDRESS
Fortmans & Gore	1723 N Eutaw St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54844 — 31 E 54844

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2500 Talbot Ave ST., 11-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Lorenz Ranch

2—FULL NAME 2500 Talbot Ave

(a) RESIDENCE NO. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) July 12-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Stiff

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Anton Raush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER = = =

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Barbara Raush

(Address) 2500 Wilkens Ave

15 Filed MAR 9 - 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to Mar 8, 1930, that I last saw him alive on Mar 6, 1930, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows: Pulmonary Oedema

CONTRIBUTORY (Secondary) Pulmonary Embolism (duration) yrs. 7 mos. 28 ds.

Cirrhosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical findings

What test confirmed diagnosis? Clinical findings

(Signed) J. C. Hampton Jones M. D.

3/8/30 (Address) 1729 K Fondale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Mar 11 1930

20 UNDERTAKER Mr-Mrs N S Fink — ADDRESS 2512 Wilkens

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54845

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54845

CERTIFICATE OF DEATH

91-002

REGISTERED NO. 8-13

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1123 N. Bond ST., 8 WARD)

2—FULL NAME Christina Lehman

(a) RESIDENCE NO. 1123 N. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John A Lehman

6 DATE OF BIRTH (month, day, and year) Jan 19=1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	91	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Eliz. Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Annie Lehman

(Address) 1123 N. Bond st

15 Filed C. HAMPSON JONES, M. D. Registrar

MAR 9 - 1930.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1930

17 I HEREBY CERTIFY, That I attended deceased from May 20 1929, to March 7 1930

that I last saw h.... alive on March 5 1930

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

a Uraemia Nephritis

Chronic Interstitial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J C Stoner M. D.

March 8, 1930 (Address) 4900 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	March 10 1930
20 UNDERTAKER	ADDRESS
Henry Lutz	1203 N Broadway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54846

CERTIFICATE OF DEATH

90

E 54846

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 Wylie Ave ST. 27-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Utterbaugh

(a) RESIDENCE NO. 3004 Wylie Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Utterbaugh

6 DATE OF BIRTH (month, day, and year) Feb 26, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer) United R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. H. G. Fox

(Address) 3004 Wylie Ave C. HARRISON JONES, M. D.

15 Filed ... 19 Registrar

MAR 9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec, 19 29, to March 7, 19 30, that I last saw h[illegible] alive on March 7, 19 30 and that death occurred, on the date stated above, at 9.35 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Herbert Cat[illegible], M. D.

March 9, 1930 (Address) 1716 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL March 1930

20 UNDERTAKER Chunowith Son

ADDRESS 345 Chestnut

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54817 E 54817

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Olinger

(a) RESIDENCE NO. 3209 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Olinger

6 DATE OF BIRTH (month, day, and year) Jan 23/1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Martin F. Milliger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Albert Olinger

(Address) 3209 McElderry St.

15 Filed [illegible] 19 [illegible] Registrar

C. HAMPSON JONES, M. D.

APR 9 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8/30

17 I HEREBY CERTIFY, That I attended deceased from March 4 1930 to March 8 1930.

that I last saw her alive on March 8 1930

and that death occurred, on the date stated above, at 3-30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerular Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry

(Signed) Vernon H. Norwood, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Mar 11 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Eutaw St

IMPORTANT. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54848 — 90 E 54848

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. NO 1315 Argyle Ave 7-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Wright

(a) RESIDENCE. NO. 1315 Argyle Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March [illegible] 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk - Va

PARENTS

10 NAME OF FATHER Thomas Richard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Classie Rodges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William Wright.
(Address) 1315 Argyle Ave.

15 Filed MAR 9 - 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 23. 1930. to March 6, 1930.

that I last saw h[illegible] alive on March 6, 1930.

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Patk J. Murray, M. D.

19 (Address) 510 N. Dumont ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cemetery

DATE OF BURIAL Mar. 9 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Eurstman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Part statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54849 — 24-091 — 54849

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No.) 132 N. 25th. (STREET) 12-51 (WARD)

2—FULL NAME Rebecca I. Hazlett

(a) RESIDENCE NO. 132 N. 25th. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William E. Hazlett

6 DATE OF BIRTH (month, day, and year) Oct. 6-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Thomas Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Eliza J. Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant J. M. Eberhardt

(Address) 3130 Remington Ave

15 Filed ... 19 ... Registrar

MAR 9 - 1930 BALTIMORE MD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7-1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 21st, 1930, to March 7th, 1930, that I last saw h[illegible] alive on March 7th, 1930, 5.40 A. m. and that death occurred, on the date stated above, at 5.40 A. m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George G. Cross, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL March 10, 30

UNDERTAKER Horace H. Burgee — ADDRESS 363 Fallsway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54850

REGISTERED NO. 49

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 Scott ST.) 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline L. Ochse

(a) RESIDENCE NO. 1140 Scott ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced: HUSBAND of (or) WIFE of William Ochse

6 DATE OF BIRTH (month, day, and year) Oct 27. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	4	8/0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 032

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Christian Nazarenus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Maria Schlag.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Elizabeth Reynolds.

(Address) 1140 Scott St.

Filed MAR 8 - 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7. 1930,

17 I HEREBY CERTIFY, That I attended deceased (from Oct 9 1929. to Mar 6 1930. that I last saw her alive on Mar 6 1930 and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mediastinum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lung (duration) yrs. mos. 1 ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? None Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) [illegible] M. D.

3-7-1930 (Address) 1202 W. Fayette.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Mar. 10 1930

20 UNDERTAKER Mr. Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 54851

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 9-46 Ward)

2-FULL NAME Margaret M. Scales

(a) RESIDENCE NO. 2138 N. Harford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	white	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Stephen Scales

6 DATE OF BIRTH (month, day, and year) June 16 1869

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER James Connolly.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Vonkeun

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant John Scales
(Address) 2138 Harford Ave

15 Filed ..., 19... C. HAMPTON JONES, M.D. Registrar

MAR 9 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental Burns over body.
(Clothes caught from Gas range on Mar 3/30)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at her home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Patient, M. D.

3/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 3 10 1930

20 UNDERTAKER George F. Ruth 1735

ADDRESS Harford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54852 ✓ 129 E 54852

REGISTERED NO.

E 54852

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sister's Of the Poor 1614 ST., ~~Poor~~ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Henry

(a) RESIDENCE NO. Preston & Valley Streets ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Henry

6 DATE OF BIRTH (month, day, and year) Sept 26 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) West Virginia
(State or country)

PARENTS

10 NAME OF FATHER Christian Henry

11 BIRTHPLACE OF FATHER (city or town) Martinsburg.
(State or country) Va.

12 MAIDEN NAME OF MOTHER Martha Van Lill

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Little Sister's of The Poor
(Address) Preston & Valley Streets

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7-30

17 I HEREBY CERTIFY, That I attended deceased from 3/3, 1930, to 3/7, 1930, that I last saw h... alive on 3/6, 1930 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis and Endocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. Bryant Lord M. D.

3/7, 1930 (Address) 1216 E Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 3/10 1930

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

important. See instructions on back of certificate.

MAR - 1930

Spec.—M. & T.—250 Bks. Lee Lenhoff 2020 N Charles St. ✓

E 54853 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54853

89

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1441 ST., Homestead WARD 44)

2-FULL NAME Clara E. Lieben

(a) RESIDENCE NO. 1441 ST., Homestead WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw. J. Lieben

6 DATE OF BIRTH (month, day, and year) 11/5/1856

7 AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
73	3 4	X 1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS
10 NAME OF FATHER Lee
11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)
12 MAIDEN NAME OF MOTHER "
13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Mrs. Berger
(Address) 1441 Homestead

15 MAR 9 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930, to Mar 6, 1930,
that I last saw her alive on Mar 6, 1930,
and that death occurred, on the date stated above, at 6:20 a. m.

The CAUSE OF DEATH* was as follows:
angina Pectoris
(duration) yrs. 6 mos ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible] M. D.
3/8/30 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral
DATE OF BURIAL 3/10/30

20 UNDERTAKER George J. Puth
ADDRESS 1735 Harford

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54354½ | **CERTIFICATE OF DEATH** | 129 E 54354

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 515 E 21 st ST. 9-46 WARD)

2—FULL NAME William C. Rodgers

(a) RESIDENCE NO. 515 E 21 st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George W Rodgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret C McConnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Catherine B Doyle

(Address) 515 E 21 st

15 Filed 3/8, 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1928, to March 6, 1930, that I last saw him alive on March 6, 1930 and that death occurred, on the date stated above, at 5 9. m.

The CAUSE OF DEATH* was as follows:

Ch Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

3/8, 1930 (Address) 733 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 3/10, 1930

20 UNDERTAKER Robt J Turner

ADDRESS 1462 N Broadway

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54855 E 54855

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Vol. America Hospital WARD)

2-FULL NAME John F. Eichelberger

(a) RESIDENCE NO. 1909 E. 20th ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Annie C Eichelberger

6 DATE OF BIRTH (month, day, and year) Oct 15-1868

7 AGE — Years 61 Months 4 Days 21 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Construction foreman

(b) General nature of industry, business, or establishment in which employed (or employer) P. J. Hanagan 016

(c) Name of employer Sons Contractor

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Greenway Eichelberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) J. Frank Eichelberger Jr 68 Linard Street

15 Filed MAR 9 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1929, to March 8, 1930, that I last saw h[illegible]live on March 7, 1930, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Nov. 1929

Was there an autopsy? no

What test confirmed diagnosis? microscope

(Signed) A. J. Conrey, M. D.

3-8-1930 (Address) Vol. America Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 3/11 1930

UNDERTAKER William Cook

ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54856 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54856

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2515 Guilford Ave (12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Thomas Earle

(a) RESIDENCE NO. 2515 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (WIFE of) Leola M.

6 DATE OF BIRTH (month, day, and year) Oct 3 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chief Clerk (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Navy Dept

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Elkton Md

PARENTS

10 NAME OF FATHER George Earle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Queen Annes Co. Md

12 MAIDEN NAME OF MOTHER Mary Chamberlain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newark Del

14 Informant Mrs Bessie E. McPherson

(Address) 1316 N. H. Ave Wash D. C.

15 Filed ....., 19 C. HAMPTON JONES, M. D. Registrar

MAR 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/6/30

17 I HEREBY CERTIFY, That I attended deceased from September 1, 19 29, to March 6, 19 30, that I last saw h. alive on March 6, 19 30, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) - yrs. - mos 2 ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis and myocarditis (duration) over 5 months yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No.

What test confirmed diagnosis? Clinical data.

(Signed) Henry C Ohle M. D.

3-7, 1930 (Address) 1203 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft. Lincoln Md Cemetery DATE OF BURIAL 3/9/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54857

CERTIFICATE OF DEATH

112

E 54857

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 410 S Exeter St. 3-5 Ward)

2-FULL NAME Mary Josephine Gallo

(a) RESIDENCE NO. 410 S Exeter St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec 17 1913

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	16	2	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto

PARENTS

10 NAME OF FATHER Ferdinand Gallo

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Lena Delsina

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Dominick Gallo
(Address) 410 S Exeter St

15 Filed MAR 9 - 1930 16 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: AC Endocarditis (Sausage) Emb of Art.

(duration) yrs. mos. 7 hr

CONTRIBUTORY (Secondary) AC tonsilitis Infection

(duration) yrs. mos. 4 da

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo Wades, M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL March 10 1930

20 UNDERTAKER M. F. E. Duppler Inc.

ADDRESS 37 Saint

Information should be carefully supplied. AGE should be stated EXACTLY. THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54858

CERTIFICATE OF DEATH.

90 E 54858

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 (St.) Woodington Ave (Ward) 16-66

2-FULL NAME Katie Smith

(a) RESIDENCE NO. 704 (Usual place of abode) Woodington ST., WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Smith

6 DATE OF BIRTH (month, day, and year) April 15-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (37)

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Joseph Smith (Address) 704 Woodington Ave

15 Filed 1930 C. RAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 0, 1930, to March 7, 1930.

That I last saw her alive on March 6, 1930, and that death occurred, on the date stated above, at 5 45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Mitral Insufficiency - Arteriosclerosis

(duration) Months ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. C. Fisher, M. D.

3/7, 1930 (Address) 215 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Mar. 10 1930

20 UNDERTAKER George L. Lethwaite — ADDRESS Frederick Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R9

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

54859 166 E 54859

REGISTERED NO.

1-PLACE OF DEATH
City of Baltimore: (No.) W. Balto Gen Hosp St. 15-62 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Naomi Lemmon

(a) RESIDENCE NO. 3102 Sequoia St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem
4 Color or Race: White
5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): 1902

7 AGE: Years 27 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General naturo of industry, business, or establishment in which employed (or employer):
(c) Namo of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Geo. Lemmon

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Margetta Leishear

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Md.

14 Informant: Geo. Lemmon
(Address): Woodbine Md.

Filed MAR 9 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) Inquest thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to (her) death on the day stated above, Tho CAUSE OF DEATH was as follows:

Pulmonary Edema

(duration) 3 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Bichloride Mercury

(duration) yrs. mos. 5 ds.

18 Whero was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

May 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lisbon Md.

DATE OF BURIAL: May 11 1930

20 UNDERTAKER: Penn Dow Inc

ADDRESS: Sykesville Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly. Every question on OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54860 — 100 E 54860 — 001 ✓

REGISTERED NO. .....

1-PLACE OF DEATH Sinai Hospital ST. 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Mr. Frank Galombek.

(a) RESIDENCE NO. 1918 Wilkins ave ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Lillie Galombek

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	—	

8 OCCUPATION OF DECEASED Tailor

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Galombek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sohl —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Baltimore St

15 Filed APR 9 - 1930 19 C. H. [illegible] Registrar

For ..... ST. LOUIS, MO.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7 , 19 30 . to Mar 9 , 19 30.

that I last saw him alive on Mar 9 , 19 30.

and that death occurred, on the date stated above, at 6:30 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, B.O.A.D.

Lung abscess.

(duration) ..... yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & lab. findings

(Signed) Bernard Cohen M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mosh Road

DATE OF BURIAL 3/9 1930

20 UNDERTAKER Jack Lewis 1439 E Balto St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54361

CERTIFICATE OF DEATH.

24-3474-001

E 54361

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1737 Light St. 24-34 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Katherine Peters

(a) Residence No. 1737 Light St. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm. H. Peters

6-DATE OF BIRTH (month, day and year) March 27. 1865

7-AGE. 64 yrs. 11 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town)... Balto., Md.
(State or Country),

PARENTS.

10-NAME OF FATHER. Michael Engelhart

11-BIRTHPLACE OF FATHER (city or town) Germany
(State or Country),

12-MAIDEN NAME OF MOTHER. Barbara Oppel

13-BIRTHPLACE OF MOTHER (city or town) Germany
(State or Country),

14- (Informant)... Wm. H. Peters

(Address)... 1737 Light St

15- MAR 9 - 1930 192... H. AMMON JONES, M. D. Registrar.

By ..... P.H.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 5, 1930

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930 to Mar. 5 1930

that I last saw HER alive on Mar. 5 1930

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemhorage

(Duration) ... yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ... yrs. ... mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. & Campbell M. D.

3/7 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill Cem. DATE OF BURIAL. March 10. 1930

20-UNDERTAKER. Margaret L. Flynn ADDRESS 1432 Light St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54362 129 E 54362

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1314 Webster ST. 24-33 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Lauenroth

(a) RESIDENCE NO. 1314 Webster WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of: Katie Will Lauenroth

6 DATE OF BIRTH (month, day, and year): Oct. 30. 1875

7 AGE: Years 54 | Months 4 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm. Lauenroth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Katie Lauenroth

(Address) 1314 Webster St

15 Filed 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929 to March 8, 1930

that I last saw him alive on March 7, 1930

and that death occurred, on the date stated above, at p m.

The CAUSE OF DEATH was as follows*

Myocarditis, Chronic Nephritis, General anasarca

(duration) I don't know yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia · acute dilatation of cardiac (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Edward Torres M. D.

3-8-1930 (Address) 107 East west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: March 11 1930

20 UNDERTAKER: Margaret L. Flynn

ADDRESS: 1422 Light St.

MAR 8 1930 BALTIMORE, MD.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 51863 — 109-002 — E 51863

REGISTERED NO. 4863

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4210 Academy Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry E Canapp

(a) RESIDENCE NO. 4210 Academy Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
			14 16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Walter E Canapp

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Leona Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Walter E. Canapp
(Address) 4210 Academy Ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON GIBB, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-23 1930 to 3-8 1930, that I last saw him alive on 3-8 1930 and that death occurred, on the date stated above, at 4.00 P m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Paralysis of deglutition

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis?

(Signed) Henry Bedell M. D.

, 19 (Address) 3902 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden

DATE OF BURIAL March 19 30

20 UNDERTAKER Schumacher Son

ADDRESS 31 S Calhoun

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E54864 ✓E54864

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 F 54864

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 Penrose Ave. ST. 70-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Spedden

(a) RESIDENCE NO. 2235 Penrose Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Taylor Spedden

6 DATE OF BIRTH (month, day, and year) March 9, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William McKnew

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Ledley

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Belle Lafferty

(Address) 2235 Penrose Ave.

15 Filed 3/9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/6/30, 19..., to 3/6/30, 19..., that I last saw her alive on 3/5/30, 19..., and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Int. Nephritis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) F. P. Mencken, M. D.

3/7/30 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL Mar. 10, 1930

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54865

CERTIFICATE OF DEATH

45 E 54865

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto. Gen. Hosp. ST., 11-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary Mangano

(a) RESIDENCE NO. 118 Arlington ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lazzaro Mangano

6 DATE OF BIRTH (month, day, and year) March 18 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	79 yrs	? 11	? 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Mr — McIntyre

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Michael S. Mangano, son

(Address) 118 Arlington ave Govans

15 Filed 1930 C 19 HENDERSON JONES, M. D. Registrar

R 9

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to March 8, 1930.

that I last saw h[illegible] alive on March 8, 1930

and that death occurred, on the date stated above, at 8 04 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoids — rectal pelvic Metastasis to mesenteric nodes.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

Pulmonary edema (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Feb 27, 1930

Was there an autopsy? No

What test confirmed diagnosis? X-Ray & operation

(Signed) E. A. Lolsmyer, M. D.

19 (Address) 1213 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 3/10/30

20 UNDERTAKER W. M. Boulton 2238 N. Paca St. — ADDRESS

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks. Wenzel Basel. ✓ E 54866.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54866

CERTIFICATE OF DEATH.

9 [illegible] E 54866

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227. N. Montford St. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wenzel Basel.

(a) RESIDENCE NO. 1227. N. Montford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Maria. Basel.

6 DATE OF BIRTH (month, day, and year) Oct. 6/1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63.	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer) Eichmann

(c) Name of employer [illegible]

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER W. Basel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Basel (Address) 1227. N. Montford ave

15 Filed [illegible] 19 [illegible] H. [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 6, 1930, that I last saw h[illegible] alive on March 5, 1930, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) [illegible] yrs. mos ds.

CONTRIBUTORY (Secondary) Ed[illegible]

(duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W Whitehead, M. D.

, 19 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer cmtry. DATE OF BURIAL March 10 1930

20 UNDERTAKER Geo. J. Rust ADDRESS 1235 Harford ave

TION is very important See instructions on back of certificates.

E 54867

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54867

181-009

E 54867

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3903 W. Mulberry St. 20-71 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. Washington Willing

(Residence in Baltimore: No. 3903 W. Mulberry St. 37 St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: April (Month) 4 (Day) 1879 (Year)

7-AGE: 50 yrs. 11 mos. 4 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): (Ch...

9-BIRTHPLACE, (State or Country): Oriole Md.

PARENTS.

10-NAME OF FATHER: Henry Willing

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary Brown

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Otelia Willing

(Address) 3903 W. Mulberry St

15-

Filed ..... 192 ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar. (Month) 8 (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental. Oedema of lungs caused by fumes from Calcium Carbonate - when fire broke, while working at his trade, in building (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas H Broosle M. D. (Coroner)

3/9 1930 (Address) 3601 E Pr

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Oriole Md — DATE OF BURIAL: Mar. 11 1930

20-UNDERTAKER: Wm Flickner & Son — ADDRESS North & Pa

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 54868

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54868

CERTIFICATE OF DEATH.

REGISTERED NO. 15-67 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3000 Wolbrook Ave (ST.) (WARD)

2-FULL NAME Elizabeth S. Leland Kemp

(a) RESIDENCE NO. 3000 Wolbrook Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Charles F Kemp

6 DATE OF BIRTH (month, day, and year) May 18 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Lancaster Co Pa

PARENTS

10 NAME OF FATHER Johnson Leland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Co. Pa

12 MAIDEN NAME OF MOTHER Elizabeth A. Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lancaster Co Pa

14 Informant (Address) Jos. M. Remy 3000 Wolbrook Ave

15 Filed MAR 10 1930 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7-1930

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1927, to March 7, 1930, that I last saw h[illegible] alive on March 5, 1930, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with edema,
Chronic myocardial insufficiency
Heart failure

(duration) — yrs. 10 mos — ds.

CONTRIBUTORY (Secondary) Bronchial asthma and Bronchitis (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shamer, M. D.

3/9, 1930 (Address) 3200 N. Charles Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mar 10, 1930

UNDERTAKER J. J. Dickey, Towson — ADDRESS Towson

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54869

CERTIFICATE OF DEATH

100-001

E 54869

1—PLACE OF DEATH ~~Home for Incurables~~ REGISTERED NO. 17-49

CITY OF BALTIMORE: (No. 40th & Keswick Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary P. Allen

(a) RESIDENCE NO. 404 ~~3509 N. Calvert St~~ Westlobbe Road ~~St. Louis~~ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 5 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Luther W.P. Allen

6 DATE OF BIRTH (month, day, and year) Sept. 15 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George W. Paine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Amelia A. Marley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Morton F. Allen

(Address) 3509 N. Calvert St

15 Filed MAR 10 1930 H. LAWRENCE JONES, M. D. Registrar

MAR 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930. to March 8, 1930.

that I last saw her alive on March 7, 1930.

and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

— (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H. S. Wiles, M. D.

19 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL Mar 10 1930

20 UNDERTAKER Wm J Dickner & Sons

ADDRESS North Ave

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54870

CERTIFICATE OF DEATH.

REGISTERED NO. E 54870

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 535 Beaumont ave ST. 7-1-46 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Mrs. John Farrell

(a) RESIDENCE NO. 535 Beaumont ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Farrell

6 DATE OF BIRTH (month, day, and year) 28th Feby 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	"		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Luke Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Joseph Farrell

(Address) 535 Beaumont ave

15 Filed APR 1 01930 C. HAMPTON [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 7, 1930, that I last saw him alive on March 6, 1930, and that death occurred, on the date stated above, at 5.15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Carl J. Beuer, M. D.

, 19 (Address) 5111 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cem DATE OF BURIAL 3/10 1930

20 UNDERTAKER J. J. Fahey ADDRESS 1318 Light St

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54871

CERTIFICATE OF DEATH

129 E 54871

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1518 Mt. Royal Ave. St., 14-20 WARD)

2—FULL NAME John P. Kavanagh

(a) RESIDENCE NO. 1518 Mt. Royal Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) April 16, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant to President

(b) General nature of industry, business, or establishment in which employed (or employer) of International

(c) Name of employer Freight Corp. of

9 BIRTHPLACE (city or town) Howard County
(State or country) Maryland

PARENTS

10 NAME OF FATHER Martin Kavanagh

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Fahert[illegible]

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Miss Margaret Kavanagh
(Address) 1518 Mt. Royal Avenue

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 9, 1930, to March 8, 1930
that I last saw him alive on March 8, 1930
and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) M. O'Neill, M. D.

3/9, 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/11 19 30

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54872

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

21 ✓

E 54872

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E. Karlson

(a) RESIDENCE NO. 225 E. Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Karl Wm Karlson

6 DATE OF BIRTH (month, day, and year) April 17, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover, Pa.

PARENTS

10 NAME OF FATHER J. Eppler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cape of Good Hope

12 MAIDEN NAME OF MOTHER Caroline Horn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Pa

14 Informant Karl Wm Karlson

(Address) 225 E Lafayette Ave

15 Filed MAR 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1930

17 I HEREBY CERTIFY That I attended deceased from March 5, 1930, to March 8, 1930, that I last saw her alive on March 8, 1930 and that death occurred, on the date stated above, at 11 15 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas of Leg

(Idiopathic)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Fell, M. D.

3/9, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 3/12 1930

20 UNDERTAKER: Henry W. Mears and Son — ADDRESS: 805 N. Calvert

See instructions on back of certificates. Important.

Spec.—1-30—M. & T.—250 Blks.

E 54873 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 ✓ E 54873

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 Charlotte ave ST. 26-37 WARD)

2-FULL NAME Frank McNew

(a) RESIDENCE NO. 1522 Charlotte ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella McNew

6 DATE OF BIRTH (month, day, and year) Sept 24 - 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	11 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 067

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Standard Oil Co.

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Frank McNew Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Freda Walt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Ella McNew

(Address) 1522 Charlotte ave

15 Filed MAR 10 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1930, to Mar 7, 1930, that I last saw him alive on Mar 6 1930, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) Sudden yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tetlow, M. D.

3/8, 1930 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL Mch 11 1930

20 UNDERTAKER George W. Zukler

ADDRESS 1737 E. Eager st.

ATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54874

E 54874 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3100 Elliott ST. 1-1 WARD)

2-FULL NAME George H. Bauersfeld

(a) RESIDENCE NO. 3100 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 17-1928

7 AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	1	2	15 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Bauersfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Carrie Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant George Bauersfeld (Address) 3100 Elliott St.

15 Filed MAR 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 19 30, to March 8, 19 30, that I last saw him alive on March 7, 1930, and that death occurred, on the date stated above, at 12.50 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) I. B. Bronushas, M. D.

3-8-30 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Pauls Cemetery

DATE OF BURIAL Mch 10 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager st

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ **E 54875**

E 54875

CERTIFICATE OF DEATH

REGISTERED NO. 12-50

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2907 St Paul ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Duncan Veazey

(a) RESIDENCE NO. 2907 St. Paul ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Annie K. Veazey

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	x	22 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) x

(c) Name of employer x

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Rowland Veazey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton, Talbot Co Md

12 MAIDEN NAME OF MOTHER Eliza Duncan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Henry Rowland Veazey

(Address) 2907 St Paul Street

15 Filed MAR 10 1930 J. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to March 9th, 1930, that I last saw h[illegible] alive on March 8th, 1930, and that death occurred, on the date stated above, at 8-30 a. m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage causing Hemiplegia & Coma (a) Primary Cause

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferis Buck, M. D.

3/10, 1930 (Address) 100 E. Eager Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL March 10 1930

20 UNDERTAKER Henry D Jenkins & Co ADDRESS Eden & Gay Sts

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

23472 E 54876

REGISTERED NO. E 54876

100-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn Wunlap

(a) RESIDENCE NO. 1928 E. Eager ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	Infant

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1930 Baltimore

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4 weeks	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Wunlap

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Louise Waddell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Registrar

MAR 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930, to March 4, 1930

that I last saw her alive on March 4, 1930

and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 6 da.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? None

(Signed) Alexander Custon, M. D.

, 19 (Address) Johns Hopkins Hosp. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmell Cem

DATE OF BURIAL 3/10/30 19

ADDRESS 221 Bway

20 UNDERTAKER Joseph Ahrens

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54877

E 54877

CERTIFICATE OF DEATH

Curtis Bay 14-001

REGISTERED NO. 2577

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3605 Lee ST., 25th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Hall

(a) RESIDENCE NO. 3605 Lee ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgie A Hall

6 DATE OF BIRTH (month, day, and year) Dec 25 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Henry Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Georgie A Hall

(Address) 3605 Lee St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23 1930 to Mar. 7 1930

that I last saw him alive on Mar. 6 1930

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Frost M. D.

Mar 7 1930 Address 4805 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL Mar 10 1930

20 UNDERTAKER John H. Denny

ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54878

E 54878

CERTIFICATE OF DEATH.

REGISTERED NO. 23

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 710 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Meisenhalter

(a) RESIDENCE NO. 2118 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pierce Meisenhalter

6 DATE OF BIRTH (month, day, and year) DEC 9. 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	48	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Hanger

(b) General nature of industry, business, or establishment in which employed (or employer) Piano

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Simon Meisenhalter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Pauline Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Pierce Meisenhalter (Address) 2118 Jefferson St

15 Filed MAR 10 1930, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-6 .1930. to 3-8 .1930.

that I last saw h alive on 3-8 .1930.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica

(duration) yrs. mos 5 weeks

CONTRIBUTORY (Secondary) Paralysis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & surgical

(Signed) Wm Hendrix M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dove Mercy Cem

DATE OF BURIAL Mar 2 1930

20 UNDERTAKER John Mrich

ADDRESS 2009 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 10 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51 E 54879

E 154879 DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2006 Jefferson ST., 7-10 WARD)

2—FULL NAME Katie Donnetta Meinfelder

(a) RESIDENCE NO. 2006 Jefferson ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced (or) WIFE of: Ernest Meinfelder

6 DATE OF BIRTH (month, day, and year): May 20-1868

7 AGE: Years 61 | Months 9 | Days 17 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Halle Md

PARENTS

10 NAME OF FATHER: Casper Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Ehrlicher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louisa Lang
(Address) 2006 Jefferson St

15 Filed ..... 19... Registrar

MAR 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to March 9, 1930, that I last saw her alive on March 8, 1930 and that death occurred, on the date stated above, at 3 1/4 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Edward J. Kost M. D.

3/9, 1930 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem

DATE OF BURIAL: Mar 11 1930

20 UNDERTAKER: D. Stan Ulrich

ADDRESS 2008 Eutaw

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54880 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54880

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1413 N May St. (Ward) 8-17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Weibel

(a) RESIDENCE NO. 1413 N May St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gretchen Weibel

6 DATE OF BIRTH (month, day, and year) Mar 16-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Mrs Ruzicka

(Address) Edmondson Ave

15 Filed ..... 19 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8th 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 7, 1930, to Mch 8, 1930, that I last saw him alive on Mch 8, 1930, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. moe ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl Fisher, M. D.

3/8, 1930 (Address) 1503 N Mad Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

UNDERTAKER John Ulrich

DATE OF BURIAL Mch 10 1930

ADDRESS 2008 Eutaw

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54881

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54881

CERTIFICATE OF DEATH

10-001

REGISTERED NO. 25-72

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine O'Brien

(a) RESIDENCE NO. 1502 DeSoto Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Marie Luber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. Chas. O'Brien

(Address) 1502 DeSoto Road

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9. 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to March 9, 1930,

that I last saw her alive on March 9, 1930

and that death occurred, on the date stated above, at 3.50 a. m.

The CAUSE OF DEATH* was as follows:

Tonsillar Pharyngeal & Laryngeal Diphtheria

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pos. Culture

(Signed) Myron E Zell, M. D.

3/9, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Mar. DATE OF BURIAL 10 30 19

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul

important. See instructions on back of certificates.

Dr Rajicka Patterson Park

Spec.—8-16-29—L. F. S.—100 Bks.

E 54882

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54882

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2728 E Chase ST. 8-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dino J. Valentini

(a) RESIDENCE NO. 2728 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Dec. 19-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Vincent Valentini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Battista

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Valentini (Address) 2728 E Chase St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-6-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1929 to 3 6 1930, that I last saw h[illegible] alive on 3 6 1930 and that death occurred on the date stated above, at 3 20 P.M.

The CAUSE OF DEATH* was as follows:

Primary Pain Gen

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Collapse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of about 1-7.

Was there an autopsy? No Findings

What test confirmed diagnosis?

(Signed) [illegible] M.D.

(Address) 806 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar 10 1930

20 UNDERTAKER William Cook — ADDRESS 1217 S Paul.

important. See instructions on back of certificates.

MAR 10 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54883

CERTIFICATE OF DEATH

129 ✓ E 54883

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 Leo ST. 27-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter Nowakowski

(a) RESIDENCE NO. 1610 Leo ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Nowakowski

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Nowakowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Nowakowski

(Address) 1616 Leo St.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9-30

17 I HEREBY CERTIFY, That I attended deceased from 1928, 19..., to March 7, 1930, that I last saw h— alive on March 7, 1930 and that death occurred, on the date stated above, at 1130 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis

Chronic Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Bosca M. D.

(Address) 4720 Fairmount Ave. March 9, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A&C Co DATE OF BURIAL March 11 1930

20 UNDERTAKER A. W. Bazewski 1930 ADDRESS Eastern Ave

important. See instructions on back of certificates.

R 10 1930 C. Hamilton Johns M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54884

CERTIFICATE OF DEATH

143 1901 **E 54884**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 13-59 Ward)

2-FULL NAME Lessie Ross

(a) RESIDENCE NO. 2530 Madison Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James Ross

6 DATE OF BIRTH (month, day, and year) Mar ch 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. Thumberland Co., Va.

PARENTS

10 NAME OF FATHER Wm. Rich

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Drucillia Thompson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant James Ross
(Address) 2530 Madison Ave

16 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonitis- Abortion (about 4 mon)
(Probably accidental- no history)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of bet Feb 27 & Mar 5th

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. H. Owen, M. D.

3/9/30 (Address) 508 E. North Ave

*State the Disease Causing Death, ar in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
North Thumberland Va	3/10/1930
UNDERTAKER	ADDRESS
Mrs. Geo. H. Holland	1631 Druid Hill

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54885

E 54885

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2011 Mc Culloh St. (2nd) 14-70

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Elisabeth Thomas

(a) RESIDENCE NO. 2011 McCulloh St. Ward Atlantic City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widowed

5a If married, widnwed, or divorced
HUSBAND of
(or) WIFE of William

6 DATE OF BIRTH (mnnth, day, and year) ? 1891

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	39 ?			

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of wnrk Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Kirby

11 BIRTHPLACE OF FATHER (City or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Logus

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State nr country)

14 Informant Edna Brown
(Address) 2011 McCulloch St

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6-1930 19

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1930, to March 6, 1930,

that I last saw h[illegible] alive on March 6, 1930,

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Carcinomas L Breast

Myocardial Degeneration (duration) yrs. mos. ds.

CONTRIBUTORY Metastases
(Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of July 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas E Culhane M. D.

(Address) May 10 1930 1504 McCulloch

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial 3/10/30

20 UNDERTAKER Jno. Geo. H. Holland — ADDRESS 1631 Druid Hill

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

[illegible] M. D.

APR 1 0 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54886

CERTIFICATE OF DEATH

90 ✓ E 54886

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (WARD) 14-20

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Henson

(a) RESIDENCE NO. 1405 Myrtle Ave (Usual place of abode) WARD .....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 10th 1874

7 AGE: 55 Years 56; Months 11; Days 27; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O&D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elenor Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Bertha Simms

(Address) 1405 Myrtle Ave

15 Filed MAR 10 1930. H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7-30.

17 I HEREBY CERTIFY, That I attended deceased from 3-5-30, 19.., to 3-7-, 19 30

that I last saw h— alive on 3-7-, 19 30

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? — What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 427 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 3/11/1930

UNDERTAKER Chas. H. Holland

ADDRESS 1631 Druid Hill Ave

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54887 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 54887

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Luten ST. 4-7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Owen Ball

(a) RESIDENCE NO. Frederick & Delroy Ave (Catonsville ST., WARD Catonsville
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if foreign birth? 58 yrs. 6 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug-11-1871

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
58	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER David Ball

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER De Vere

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Mrs Nannie B. Kinum (sister)
(Address) 3207 N Calvert St

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8-1930

17 I HEREBY CERTIFY, That I attended deceased from 3-5, 1930, to 3-8, 1930, that I last saw h... alive on 3-8, 1930 and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiovascular disease ... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Gangrene toe ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

3/8/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 10 19 30
20 UNDERTAKER Stewart & Co	ADDRESS Balto

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54888 — 11-001 — E 54888

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Warren ave ST. 14-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia M. May

(a) RESIDENCE NO. 105 Warren ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: white | 5 Single, Married, Widnwed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND nf (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12th 1890

7 AGE — Years: 40. | Months: — | Days: 23 | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Drug + Mecha Bank

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER Wm. May

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. Md.

12 MAIDEN NAME OF MOTHER Maria Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Maria May
(Address) 105 Warren ave

15 Filed MAR 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to Mar 7, 1930, that I last saw h[illegible] alive on Mar 7, 1930 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ... yrs. ... mos. 5 da.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. 3 da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm Lebatiffe, M. D.

3/8, 1930 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: Mar 11th 1930

UNDERTAKER: Fred A. Kramer & Son

ADDRESS: 703 Hanover

(OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54889

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Mem. Hosp St. 12-49 Ward)

2-FULL NAME Harry Bish

(a) RESIDENCE NO. Fairmount & Patterson St., Ward Westminster

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Bish

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64	—	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) Own
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Bish

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Lu Gingley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Susan Bish
(Address) Fairmount & Patterson ave

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down & hit and run over (apparently) by car

Fract skull (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract L Shoulder & Contusion Rt. Hip (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Emma & Clifton

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

3/10, 1930 (Signed) C. Hampton Johns, M. D.

(Address) 2934 W. Eddy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodmont Bachman	3/12 1930
20 UNDERTAKER	ADDRESS
H H Bankard & Son	Westminster

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read QUES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 9 1930

Spec.—2-29-28—L. F. S.—500 Blks.

E 54890 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 54890

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Vance

(a) RESIDENCE NO. Preston & Gilday ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of indostry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington

PARENTS

10 NAME OF FATHER James Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Catherine Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Preston & Gilday Sts

15 Filed MAY 1 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/1, 1930 to 3/8, 1930

that I last saw h alive on 3/8, 1930

and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. B. Emmart M. D.

3/10, 1930 (Address) 1216 Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL May 11, 1930

20 UNDERTAKER Rita Weidefeld

ADDRESS 914 Gramont Ave

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54891

100 601

E 54891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 S. Decker Ave ST 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mateusz Siminski

(a) RESIDENCE NO. 1220 S. Decker Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE) of Mary Siminski

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Siminski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Margaret Jatlowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Siminski

(Address) 1220 S Decker Ave

15 Filed 3/9 19 30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-6 1930, to 3-7 1930, that I last saw him alive on 3-6 1930 and that death occurred, on the date stated above, at 8 32/60 m

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

about 4-5

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocard. insufficiency

(duration) unknown

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Jos. A. Rosenblatt, M. D.

(Address) 3018 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL 3/10 1930

UNDERTAKER Wm S. Fialkowski

ADDRESS 1020 S. Kenwood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH ITEM OF INFORMATION is very important. See instructions on back of certificates.

R 104939

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54892

CERTIFICATE OF DEATH.

46 E 54892

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 N. Luzerne ave ST. 6-10 WARD)

2-FULL NAME Bertha Rose

(a) RESIDENCE No. 401 N. Luzerne ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louisa Rose

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Philip

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Freida Levenly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Baltimore St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/30

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1930, to March 10, 1930,

that I last saw her alive on March 10, 1930;

and that death occurred, on the date stated above, at 4.9 m.

The CAUSE OF DEATH* was as follows:

carcinoma cervix —

Had carcinoma of uterus - 1 year ago about - operated upon —

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Malignant tuberculous oedema —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of 1 year ago

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis F. Krumenacker, M. D.

3/10, 1930 (Address) 722 N. Lemmon ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 3/10 1930

20 UNDERTAKER Jack Lewis 1439 E Balto St — ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 54893

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54893

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Cullard ST. 7-13 WARD)

2-FULL NAME Harry Coonin

(a) RESIDENCE NO. Levindale Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced (HUSBAND of) (or) WIFE of: Rebecca Coonin

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 58 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1429 E Baltimore St

19 [illegible] 19 [illegible] Registrar

MAR T 0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1930

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1930, to March 10, 1930, that I last saw him alive on March 10, 1930, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab & Clinical

(Signed) A. S. Gluck M. D.

3/10, 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 3/10 1930

20 UNDERTAKER: Jack Lewis — ADDRESS: 1429 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 54894

E 54894

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 929 S. Sharp St ST. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Philip Johnson

(a) RESIDENCE NO. 929 S. Sharp St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) East Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Johnson

(Address) 929 S Sharp Street

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to March 6, 1930

that I last saw h alive on March 5, 1930

and that death occurred, on the date stated above, at 4.5 A, m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. 1½ ds.

CONTRIBUTORY (Secondary) Id Obstruction

(duration) yrs. mos. 1½ ds.

18 Where was disease rontracted if not at place of death? Home

Did an operation precede death? N D Date of —

Was there an autopsy? N D

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. R. Thomas M. D.

(Address) 712 S Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Albion Cemetery

DATE OF BURIAL 3/10 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 139 W. Lanvale St.

CHARLES H. JONES, M. D.

MAR 10 1930

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 ✓

E 54895

REGISTERED NO. E 54895

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 4 30 WARD)

2-FULL NAME Baby Boy Rilley, 1218 Arch St Pittsburg Pa

(a) RESIDENCE NO. Univ Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-1-30

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ---

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas James Rilley

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York, N.Y.

12 MAIDEN NAME OF MOTHER Mary Pemberton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y. - N.Y.

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 10 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3-30 19

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 3, 1930,

that I last saw him alive on 3-3-30, 19

and that death occurred, on the date stated above, at 1 - a. m.

The CAUSE OF DEATH* was as follows:

Prematurity 2 wks.

Spontaneous Abortion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fernand H Lang M. D.

3/3. 1930 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

UNDERTAKER

ADDRESS MAR 6 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54896

CERTIFICATE OF DEATH

113

E 54896

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1217 Lanvale St., 16-23 Ward)

2-FULL NAME Doris Payne

(a) RESIDENCE NO. 1217 Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no 1928

6 DATE OF BIRTH (month, day, and year): Oct 2 - 1929

7 AGE: Years 1 | Months 5 | Days 3 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER: Joe Payne

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Ida V. Hazelhan

13 BIRTHPLACE OF MOTHER (city or town): Unknown
(State or country) Md

14 Informant: Ida Payne
(Address) 1217 Lanvale St.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Colin Smith, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

MAR 8 - 1930

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 10 1930

Spec.—1-10-21—M&T—1500 Bks.

E 54897

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54897

CERTIFICATE OF DEATH.

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 7-9 WARD)

2-FULL NAME Baby Boy Mashkes.

(a) RESIDENCE No. 5396 Monument St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-5-30

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Morris Mashkes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Gillman Goldsmith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland.

14 Informant (Address)

15 Filed. 19 28 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-5 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-5 .1930. to 3-5 .1930.

that I last saw h imalive on 3-5 .1930,

and that death occurred, on the date stated above, at 10:15 Pm.

The CAUSE OF DEATH* was as follows:

Cerebellar hemorrhage. (primary)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Face Presentation - Precipitate labor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Presence of Blood.

(Signed) Michael J. Greenfield, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAR 6 - 1930

20 UNDERTAKER

ADDRESS

For Registrar of Vital Statistics

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54898

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54898

CERTIFICATE OF DEATH

161-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 N Gilmor St. 11-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Whitehead.

(a) RESIDENCE NO. 919 N Gilmore. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Black.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-4-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 919 N Gilmor St.
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Herbert Whitehead

11 BIRTHPLACE OF FATHER (city or town) Norfolk
(State or country) Va.

12 MAIDEN NAME OF MOTHER Hilda Noel.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant mother

(Address)

15 Filed 19

4107 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-4-30

17

I HEREBY CERTIFY, That I attended deceased from 3-4-30, 19, to 3-8-30, 19,

that I last saw h.. alive on 3-7-30, 19

and that death occurred, on the date stated above, at 4:00 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis:

(Signed) M. Alexander Hovey, M. D.

19 (Address) 15 16 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
S HOPKINS HOSPITAL

DATE OF BURIAL MAR 8 - 1930 19

20 UNDERTAKER

ADDRESS

GEORGE C. HAMPSON JONES, M. D.
Commissioner Health.

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54899

CERTIFICATE OF DEATH.

91-002N

E 54899

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 N. Aisquith ST., 9-18 WARD)

2-FULL NAME Laura Johnson

(a) RESIDENCE NO. 1319 Aisquith ST., 9- WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John B. Johnson

6 DATE OF BIRTH (month, day, and year): Oct. 17-1845

7 AGE — Years: 84 Months: 4 Days: 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Homework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

PARENTS

10 NAME OF FATHER: John Worden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Martha

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Wm. Johnson

(Address): 1319 Aisquith St

15 Filed MAR 10 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 8- 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 22- 1927 to Mar. 8- 1930, that I last saw her alive on March 7- 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Arterial sclerosis

no hemorrhage

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

3/10/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: March 10th, 1930

UNDERTAKER: Geo J. Pust

ADDRESS: 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. DEFINITE AND SPECIFIC STATEMENT OF CAUSE OF DEATH IS very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

2-44405 E 54900

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-00-1 E 54900

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fred Smith

(a) RESIDENCE NO. 918 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Car

PARENTS

10 NAME OF FATHER Lars Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Car

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 10 1930, 19 [illegible] Registrar

MAR 10 1930 4185

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 4-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to March 4, 1930, that I last saw h im alive on March 4, 1930, and that death occurred, on the date stated above, at 12:25 A m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the liver

Chronic nephritis → Uremia

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/1/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) George S. Finney, M. D.

3/4/30 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL MAR 10 1930 19

20 UNDERTAKER

ADDRESS

Commissioner Health

Fill in all parts with pencil. See instructions on back of certificates. Be sure to write plainly. All items important.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54901

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 54901

REGISTERED NO. 9-46

1—PLACE OF DEATH
CITY OF BALTIMORE (No. 1764 Gorsuch Ave ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick J. Parr

(a) RESIDENCE NO. 1764 Gorsuch ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 6 mos. 11 ds. How long in U. S., if foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Christina M. Parr

6 DATE OF BIRTH (month, day, and year) Aug. 17 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	6	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing Trimmer
(b) General nature of industry, business, or establishment in which employed (or employer) 080
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Conrad Parr
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Katherine Brock
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Christina M. Parr
(Address) 1764 Gorsuch Ave

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR - 8 1930

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1930, to March 8, 1930, that I last saw h... alive on March 8, 1930, and that death occurred, on the date stated above, at 5.01 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Carcinoma - Lung

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? X

(Signed) John A. Schenuit, M. D.
3/9 1930 (Address) 1337 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery
DATE OF BURIAL March 12 30

20 UNDERTAKER Henry Houck & Sons
ADDRESS 1301 E. Eager St.

MAR 10 1930 H. LAMPRECHT, M. D. Registrar

Use BLACK ink in plain letters. Be sure that every item is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54902

74-001 ✓

E 54902

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 18-N Ward)

2-FULL NAME Geo. Dixon

(a) RESIDENCE NO. 713 Edmondson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Co

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sadie

6 DATE OF BIRTH (month, day and year): May 10-1887

7 AGE: Years 42 | Months 6 | Days 24 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Public Mod.
(b) General nature of industry, business, or establishment in which employed (or employer): Porter 070
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo Dixon

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Cook

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant: Mary E. Blake
(Address) 618 N. Carey

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to. his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy) (duration) Few hours

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) Fred Zeik, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	Mar. 10, 1930
20 UNDERTAKER	ADDRESS 322
Mrs. Katie R. Williams	N. Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 10 1930

HEALTH DEPT. BALTIMORE, MD.

Spec.—3-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54903

CERTIFICATE OF DEATH

31 E 54903

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 N. Curley ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Winifred M. Hoffman

(a) RESIDENCE NO. 143 N. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Hoffman

6 DATE OF BIRTH (month, day, and year) Jan. 11 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	1	29 28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer): C. & P. Telephone Co.

(c) Name of employer: Balto. Maryland.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Eugene McKee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Winifred Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Winifred McKee

(Address) 143 N. Curley St.

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15 1929 to March 9 1930

that I last saw her alive on March 9 1930

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry O'Reilly M. D.

3/10 1930 (Address) 2504 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: March 12 1930

20 UNDERTAKER: Grant V. Papitone — ADDRESS: 261 E. Balto St

important. See instructions on back of certificates.

MAR 10 1930 H. EDMONSON JONES, M.D. Registrar

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 54904

REGISTERED NO.

E 54904

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1419 E Fayette St (Ward) 45-8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Johnson

(a) RESIDENCE NO. 1419 E Fayette St (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marian Johnson

6 DATE OF BIRTH (month, day, and year): June 7 1880

7 AGE: 49 Years 8 Months 26 Days — IF LESS than 1 day ___ hrs. or ___ min.

50 - 10 - 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): 004

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER — Johnson

11 BIRTHPLACE OF FATHER (City or town) Wash. D.C. -

(State or country)

12 MAIDEN NAME OF MOTHER Whitmore

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Not known

14 Informant Mary Johnson

(Address) 1419 E Fayette St

Filed R 10 1930 C. HAMPSON JONES, M. D. Registrar

Per ADA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7 / 1930

I HEREBY CERTIFY, That I attended deceased from Dec 7 1929 to Mar 7 1930

that I last saw him alive on Mar 5 1930

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Aneurism of Aorta.

(duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary) not known

(duration) yrs. mos. da.

18 Where was disease contracted? Not known

if not at place of death?

Did an operation precede death? none Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R L Eastwick M. D.

(Address) 15 14 E Balto St

*State the Disease Causing Death, or Immediate Cause. Violent Cases, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery

Date of Burial: March 11 1930

20 UNDERTAKER: Edward Bryan

ADDRESS 1681 orleans st

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54905

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54905

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lydia Dando

(a) RESIDENCE NO. Derry Pa ST. WARD A-3
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest J

6 DATE OF BIRTH (month, day, and year) June-19-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8	19 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Charles Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Eliz Cerin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

R 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to March 10, 1930, that I last saw h.er alive on March 10, 1930 and that death occurred, on the date stated above, at 105 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of gall bladder, with extensive peritoneal metastases.

Symptoms 2 months.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Same.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? Yes. Date of Mar. 5, 1930.

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Raymond C. Ferris M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Derry, Pa.	May 10 1930
20 UNDERTAKER Geo M. Fink & Son	ADDRESS 541 N Wolfe

OF DEATH in plain terms, so that it may be easily understood. important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54906

CERTIFICATE OF DEATH

129 E 54906

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 N. Caroline ST., 10-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Monzella Saunders

(a) RESIDENCE NO. 802 N. Caroline ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fr	C	M

5a If married, widowed, or divorced
HUSBAND of
(er) WIFE of Pinkie Saunders

6 DATE OF BIRTH (month, day, and year) Apr 9 - 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Prospect
(State or country) Va

PARENTS

10 NAME OF FATHER Major Allen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Annie Davenport

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Pinkney Saunders
(Address) 802 N. Caroline

15 Date Received MAR 10 1930, 19
Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9-30

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1925, to 3-9, 1930, that I last saw he alive on 3-8, 1930 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration
Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. B. Butler, M. D.

, 19 (Address) 425 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Mch 11 1930
20 UNDERTAKER	**ADDRESS**
Sam'l N. Chase & Son	1100 Mosher

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54907

CERTIFICATE OF DEATH.

90 E 54907

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 44 Poultney St. 23-32 WARD)

2-FULL NAME Josephine Sortino.

(a) RESIDENCE NO. 44 Poultney St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Sortino

6 DATE OF BIRTH (month, day, and year) Feb 6-167

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —— 037

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Michael Romenda.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Josephine Sposi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Joseph Sortino

(Address) 44 Poultney st

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

R 1 0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to Mar 8, 1930, that I last saw her alive on Mar 8, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cardiac Renal Disease (duration) 6 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wilbur F. Littlefield M. D.

3-10, 1930 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemtery. DATE OF BURIAL March. 1930

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford

CAUSE OF DEATH. See instructions on back of certificate.

TION is very important.

Spec. 130 M. & T.—200 Blks.

(Kitzthum) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54908 E 54908

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 Harford ave 12-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lamar C. Kitzthum.

(a) RESIDENCE NO. 2024 Harford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late. William Kitzthum

6 DATE OF BIRTH (month, day, and year): Feb. 4 1864

7 AGE: Years 65 Months 11 Days 4 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hammerer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Becker.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Elizabeth Black.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: John Kitzthum

(Address) 2024 Harford ave

15 Filed 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 1930

17

I HEREBY CERTIFY, That I attended deceased from Aug, 1924, to March 8, 1930, that I last saw h[illegible] alive on March 5, 1930, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis

(Central Syphilis)

(duration) 10 yrs. — mos — da.

CONTRIBUTORY (Secondary): Hemiplegia

(duration) 1 yrs. 7 mos. — da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? physical

(Signed) Milton P. Hill, M. D.

, 19 (Address) Wylie ave - Rochester Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: March 1930

20 UNDERTAKER: Geo. F. Ruth

ADDRESS: 1735 Harford ave

TION is very important. See instructions on back of certificates.

R 1 G 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54909

CERTIFICATE OF DEATH

172 E 54909

12-50

1-PLACE OF DEATH

City of Baltimore: (No. American Building. St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beaton S. Kirby.

(a) RESIDENCE NO. 2100 N. Calvert St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. — How long in U. S., If of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Ida G. Kirby.

6 DATE OF BIRTH (month, day, and year) July 8, 1876

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
53	8	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance Manager
(b) General nature of industry, business, or establishment in which employed (or employer) Columbus Mutual.
(c) Name of employer

9 BIRTHPLACE (city or town) St. Michaels, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Nicholson Kirby.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Nahalia E. Bryan.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Ida G. Kirby. (wife)
(Address) 2100 N. Calvert St.

15 Filed ..., 19... G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull, jumped from the 10th story window of the American Building. Suicide.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

3/10 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	March 11, 1930
20 UNDERTAKER	ADDRESS
Horace F. Burgee	631 Falls Rd.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54910

CERTIFICATE OF DEATH.

90 E 54910

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1735 Abbottston St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Emma A Bennett

(a) RESIDENCE NO. 1735 Abbottston St. 11 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Levis T. Bennett

6 DATE OF BIRTH (month, day, and year) Aug 9 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	71	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles A. Silence

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie C. Collins

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Maryland

14 Informant Mrs Jennie M. Bennett

(Address) 1736 Abbottston St

1 0 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 8, 1930, that I last saw her alive on March 7, 1930, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBITORY (Secondary) Hughes Blood pressure (duration) 9 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred T. Zimmerman, M. D.

(Address) 9 S 5 9 Maryland

3/9, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial March 11 1930

20 UNDERTAKER Frederick Lassahn ADDRESS 5 S Fulton

OF DEATH in proper spaces; fill every blank with word or very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54911

CERTIFICATE OF DEATH

Raspeburg E 54911

REGISTERED NO. 26-42

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 4311 Wiltshire Ave (WARD)

2—FULL NAME Benjamin F Williams

(a) RESIDENCE NO. 4311 Wiltshire Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Estelle M Williams

6 DATE OF BIRTH (month, day, and year): Jan 14/1859

7 AGE: Years 71 | Months 1 | Days 22 | If LESS than 1 day, hrs. or min. 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 015

(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter + Builder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Taylor Fairmount Md

PARENTS

10 NAME OF FATHER: Benjamin C Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Somerset Co Md

12 MAIDEN NAME OF MOTHER: Sarah Townsend

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Somerset Co Md

14 Informant: Mrs Estelle M Williams

(Address) 4311 Wiltshire Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 29 19 29 to March 8 19 30

that I last saw him alive on March 8 19 30

and that death occurred, on the date stated above, at 9 25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Entero-Colitis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H L Beckwith, M. D.

(Address) 320 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: March 11 1930

20 UNDERTAKER: John F Penny — ADDRESS: 715 L St

important. See instructions on back of certificates.

RT 0 1930 C. HAMPSON JONES, M.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54912 90 E 54912

1-PLACE OF DEATH. REGISTERED NO.

City of BALTIMORE: (No. 2334 W. Mosher St. 16-68 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Barrett

(a) RESIDENCE NO. 2334 W. Mosher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Thomas Barrett

6 DATE OF BIRTH (month, day, and year): Mar. 16, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	64	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER: Anton Leonhardt

11 BIRTHPLACE OF FATHER (city or town): (State or country) Germany

12 MAIDEN NAME OF MOTHER: Madaline Wittman

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Germany

14 Informant: Mr. William L. Barrett

(Address) 2102 Ramsey St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 7. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed) C. H. Smith M. D.

(Coroner)

Mar 8 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: March 11 1930

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

22-002

E 54913

E 54913

CERTIFICATE OF DEATH

REGISTERED NO. 27-57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5100 Palmer Ave. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. John M. Humrickhousen

(a) RESIDENCE NO. 5100 Palmer Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George Humrickhousen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Oest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary Hinder (Sister)

(Address) 5100 Palmer Ave.

15 Filed ... 19 ... Registrar

C. HAMPSON JONES, M. D.

MAR 1 0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8/30

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to Mar 8, 1930, that I last saw h... alive on Mar 8, 1930 and that death occurred, on the date stated above, at 1 Pm.

The CAUSE OF DEATH* was as follows: Cancer of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C. H. Houston, M. D.

3-10, 1930 (Address) 8 W. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL 3/11/30

20 UNDERTAKER Harry S. Witzke, 4101 — ADDRESS Edmondson Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 54914

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54914

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp ST., 16-6 (WARD) 185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Winkleman

(a) RESIDENCE NO. 2915 W Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late) Kate nee Lambert

6 DATE OF BIRTH (month, day, and year) April 6, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	81	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER John Winkleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Edith Bell

(Address) 2915 W. Lanvale St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

R 3/1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1930, to March 3, 1930, that I last saw h[illegible] alive on March 3, 1930 and that death occurred, on the date stated above, at 1252 A. m.

The CAUSE OF DEATH* was as follows:

Fracture neck right femur

(duration) yrs. mos 20 ds

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. A. Alessi, M. D.

3-10 1930 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3/13/30

20 UNDERTAKER Harry M. Witzke

ADDRESS 410 Edmondson Ave

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54915

CERTIFICATE OF DEATH

E 54915

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hospital St., Ward 28-11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Haying

(a) RESIDENCE NO. 414 Old Orchard Rd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 10 1930

7 AGE: Years 0 Months 0 Days 0 IF LESS than 1 day hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER Louis J Haying

11 BIRTHPLACE OF FATHER (City or town) Balto Md.

(State or country)

12 MAIDEN NAME OF MOTHER Blanche E Schmoke

13 BIRTHPLACE OF MOTHER (City or town) Balto Md

(State or country)

14 Informant Louis J Haying

(Address) 414 Old Orchard Rd.

15 E. HAMILTON JONES, M. D. Registrar

Filed APR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 19 30

17 I HEREBY CERTIFY, That I attended deceased from March 10 19 30 to March 10 19 30

that I last saw h alive on March 10 19 30

and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Birth Intoxication

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schmunk, M. D.

19 (Address) 1327 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. | Date of Burial: 3-11-30

20 UNDERTAKER: E H Hart | ADDRESS: 115 E 31st St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 1 0 1930

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54916

E 54916

CERTIFICATE OF DEATH.

74-08

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3311 Guilford Ave St. 12-50 (Ward)

2-FULL NAME Mary C. Pigger

(a) RESIDENCE NO. 3311 Guilford Av. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced (H) of (or) WIFE of Frank D. Pigger

6 DATE OF BIRTH (month, day, and year) May 18, 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	72	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Noah Deaver

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan McMahon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. Wm. Schumacher

(Address) 3311 Guilford Ave.

15 Filed ....., 19 ..... (Signed) M. D. Registrar

NCH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Chas. Norris M. D. (Coroner)

3/9, 1930 (Address) 692 Bland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Cemetery 3/11 1930

20 UNDERTAKER ADDRESS

E. J. Fenning & Son 1938 E. Lafayette Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54917

E 54917

CERTIFICATE OF DEATH

199

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 2-4 Ward)

2-FULL NAME Ignatius Sauter or Solta

(a) RESIDENCE NO. 719 S. Bond St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of Agnes Sauter

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	Bet 60-68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Frank Salto Or Sauter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Agnes Sauter
(Address) 719 S. Bond St

15 [illegible] C. HAMPSON JONES, M. D. Registrar

1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull at base
Peritonitis-Ruptured Intestine
(Homicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis? Inquest ;ar 11/30

(Signed) [signature], M. D.

3/10/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary March 13	1930
20 UNDERTAKER	ADDRESS
John M Snider	1018 Chestnut

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54918

90 E 54918

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hosp St. 7-19 Ward)

2-FULL NAME Phillip J. Eggensperger

(a) RESIDENCE NO. 423 E. 2 Det St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Mc Cann

6 DATE OF BIRTH (month, day, and year) March

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	about 65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer Odd
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Phillip Eggensperger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Tobin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Phillip Eggensperger
(Address) City Hospital

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

3/18. 1930 (Address) 2632 Portland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bonnie Brae	March 1, 1930
20 UNDERTAKER	ADDRESS
E. LeRoy Stafflen Son	125 E Mosher

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

R 1 0 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54919

CERTIFICATE OF DEATH

188-403

E 54919

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hospital St. 12-49 Ward)

2-FULL NAME Nancy Lee Hall

(a) RESIDENCE NO. University Apts. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Kentucky

PARENTS

10 NAME OF FATHER James C. Hall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Elizabeth Felix

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Kentucky

14 Informant Alexander Hall
(Address) University Apts.

15 Filed ... 19... ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: 12.38-accd.
Struck & knocked down by moving auto
as Fract Skull
Fract Tibia (duration) yrs. mos. ds.
CONTRIBUTORY Traumatic Shock
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In 100 Block W. University Pkwy
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) L A Frame, M. D.
(Address) 2939 N. Calder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lexington, Kentucky	Mar. 12 1930
20 UNDERTAKER John O. Mitchell & Sons, Mahlon B. Mitchell	ADDRESS 1900 Eutaw Place

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MAR 13 1930 C. HAMPSON JONES, M. D. Registrar

Per

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54920

CERTIFICATE OF DEATH

188-103 E 5490

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Memorial Hospital St., 12-44 Ward)

2-FULL NAME Matilda M. Hall

(a) RESIDENCE NO. University Apts. 106 W. University Parkway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if nf foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	74			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Kentucky

PARENTS

10 NAME OF FATHER James C. Hall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Elizabeth Felix

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Kentucky

14 Informant Alexander Hall
(Address) University Apts.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows: 9:30 a.m.
Struck & knocked down by auto
(Duration) Fract Pelvis - Fract Femur yrs. mos. ds.
CONTRIBUTORY (Secondary) Surgical Shock
(duration) hrs. mos.

18 Where was disease contracted if not at place of death? In this house 108 Block West Univ Parkway
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? By Clinical
(Signed) D J Fraim M. D.
3/ 10 . 1930 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lexington, Kentucky	Mar. 12, 1930
20 UNDERTAKER John O. Mitchell & Sons, Mahlon B. Mitchell	ADDRESS 1900 Eutaw Place

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

21

Spec.—8-16-29—L. F. S.—100 Bks.

234776
E 54921

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54921

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 0-9 WARD)

2—FULL NAME Maude Lockhart

(a) RESIDENCE NO. Winchester - Va ST. _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eddie -

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 42 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va -

PARENTS

10 NAME OF FATHER: Morgan Laird

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va -

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Friends -
(Address)

15 Filed _____, 19 _____ Registrar

MAR 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 10 - 30

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1930, to March 10, 1930

that I last saw her alive on March 10, 1930

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Cerebello Pontile angle, left (Acoustic Neuroma) (Cushing)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 10, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Harvey B. Gardner M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winchester Va

DATE OF BURIAL: 3/10/30

20 UNDERTAKER: Joseph Lahey

ADDRESS: 221 Bway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54922

CERTIFICATE OF DEATH

57 E 54922

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 946 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Worthington

(a) RESIDENCE NO. 519 E. 28th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred 44 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr. Worthington

6 DATE OF BIRTH (month, day, and year) Feb 3, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 07

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Gladfelter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Christina Bugan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Patient
(Address)

15 Filed MAR 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1930

17

I HEREBY CERTIFY, That I attended deceased from February 28, 1930, to March 10, 1930,

that I last saw h alive on March 10, 1930

and that death occurred, on the date stated above, at 11 35 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes

Pulmonary embolus three days after amputation of leg for gangrene

(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

(duration) yrs. mos. 6 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? Yes Date of March 7, 1930

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. T. Chamberlain, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 3/13/1930

UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Dr. Goldy 4218 Hartford Rd Ham 2028

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54923

CERTIFICATE OF DEATH.

E 54923

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 317 E. North Ave (Ward) 42-19

2-FULL NAME Louise Powell Johnson

(a) RESIDENCE NO. 317 E. North Ave St., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of J. Thomas Johnson

6 DATE OF BIRTH (month, day, and year) June 14th 1850

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79	8	26 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 37

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Lambert Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER — Massey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Helen M. Johnson
(Address) 317 E. North Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/30

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 9, 1930, that I last saw h[illegible] alive on March 9, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) L. L. Goldy, M. D.

3-10, 1930 (Address) 4218 Hartford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 3/11/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

[illegible] M. D.
MAR 1 1930

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

S. Athey Patterson Park Ave. Lombard St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54924

CERTIFICATE OF DEATH.

31 E 54924

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 S. Clinton St. 26-V WARD)

2-FULL NAME Susannah S. Casson

(a) RESIDENCE NO. 108 S. Clinton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 50 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of George R Casson

6 DATE OF BIRTH (month, day, and year) 5/19/1850

7 AGE	Years	Months	Days 20	If LESS than 1 day, ...hrs. or ....min.
	79	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) A. A. Co. (State or country) Md

PARENTS

10 NAME OF FATHER Robt Hawkins

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Cole

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant George E. Casson (Address) 64 S. Grundy st

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/1930

17

I HEREBY CERTIFY, That I attended deceased from January 1st, 1929, to March 9th, 1930,

that I last saw her alive on March 9th, 1930,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonales

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Edith V. Athey, M. D.

March 10, 1930 (Address) 100 S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 3/11/1930

20 UNDERTAKER W. S. Cook — ADDRESS 1209 St Paul st

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54925

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54925

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S. Marine Hospital, Baltimore, Md. (ST.) 12-51 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Otto Oun

(a) RESIDENCE NO. 300 S. 2nd St., Philadelphia, Pa. ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) seaman

(c) Name of employer SS Arizona

9 BIRTHPLACE (city or town) (State or country) Esthonia

PARENTS

10 NAME OF FATHER John Oun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Esthonia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Esthonia

14 Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

Filed MAR 11 1930 HAMPSON JONES, M. D. Registrar

By ....

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8, 1930

17

I HEREBY CERTIFY, That I attended deceased from January 17, 1930, to March 8, 1930,

that I last saw him alive on March 8, 1930

and that death occurred, on the date stated above, at 10:18 A.M.

The CAUSE OF DEATH* was as follows:

Rupture, traumatic, bladder

[redacted]

Due to fall

Accidental

of K. Dorsum (duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY [redacted] (Secondary)

(duration) yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death? Aboard ship

Did an operation precede death? yes Date of 1-17, 2-21 & 3-8-30

Was there an autopsy? yes

What test confirmed diagnosis? Surgical operation

(Signed) Bn Townsend, M. D.

3/8, 1930 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's, Hampden	March 11 1930
20 UNDERTAKER E. Leroy Stiffler, & Inc.	ADDRESS 125 E. North Ave.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 54926 ✓ 101 E 54926

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Vincent St. 15-22 WARD)

2-FULL NAME James Powell

(a) RESIDENCE NO. 1310 Vincent ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Delia Mackey

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O&D

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) North (State or country) Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Delia Mackey (Address) 1310 Vincent St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 7, 1930, to Mar 10, 1930, that I last saw h[illegible]alive on Mar 8, 1930, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm Thom Fee, M. D.

3/10, 1930 (Address) 908 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel cemetery — DATE OF BURIAL mar 12 1930

20 UNDERTAKER Thomas B. Kelson. — ADDRESS 1303 Eastern Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 11 1930 C HAYWOOD JONES M.D.

Spec.—1-30—M. & T.—250 Blks

E 54927

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54927

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 17-23 (WARD)

2-FULL NAME James Watkins

(a) RESIDENCE (No. 1209 Wilmer Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Alverta Watkins

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	30	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Calvert Co. (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Nellie Watkins

13 BIRTHPLACE OF MOTHER (city or town) [illegible] (State or country)

14 Informant Hospital [illegible] (Address)

15 Filed MAR 11 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to 3-8, 1930, that I last saw him alive on 3-8, 1930, and that death occurred, on the date stated above, at 6:45 P.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

Endocarditis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory.

(Signed) Jas Glennon M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Mar 11 1930

20 UNDERTAKER Thomas E. Kelly

ADDRESS 1303 Pennsylvania Ave

CAUSE OF DEATH must be plainly written, and each item answered. See instructions on back of certificates.

MAR 11 1930 HAMILTON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 54928

REGISTERED NO.

E 54928

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) John Hopkins Hosp St. 8-13 Ward)

2-FULL NAME Yetta Sachs

(a) RESIDENCE NO. 1115 Rutland ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Femal	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Benj Sachs

6 DATE OF BIRTH (month, day, and year) ~~Benj Sachs~~

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Benj Sachs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Wittens

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Robt Sachs
(Address) 1115 Rutland ave

15 Filed ..... 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10/30 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia-Diabetes -ellit.
Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Cairns M. D.

3/11/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Int Assoc

DATE OF BURIAL 3/11 1930

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Balt St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 1 1930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54929

E 54929

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Belvedere Convalescing Home (Street) 27-54 (Ward) 90

2-FULL NAME Goodman Harris

(a) RESIDENCE NO. Levindale ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 43 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): w. W.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE: 80 (Years) — (Months) — (Days) — If LESS than 1 day, hrs. ... or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Leib
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Dunkow
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Isidore Sachs
(Address) 116 W 21st

15 Filed MAR 11 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-10-1930, to 3-11, 1930, that I last saw him alive on 3-10, 1930 and that death occurred, on the date stated above, at 1.05 A. m.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease (duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 4 yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) H. Edmund Levin, M. D.
3/11, 1930 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodph Road — DATE OF BURIAL: 3/11 1930

20 UNDERTAKER: Jacob Levin 1439 E Baltimore St — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54930 — CERTIFICATE OF DEATH — E 54930

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Ford Shepard Hospital STREET OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Banks

(a) RESIDENCE NO. 439 N. Fremont Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lexington Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ruth Clark

(Address) 439 N. Fremont Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-8-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to Mar 8, 1930, that I last saw him alive on 3-8-30, 19, and that death occurred, on the date stated above, at 11-05 p m.

The CAUSE OF DEATH* was as follows:

Chron. Myocarditis

from personal history of patient few years

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Intracranial Hemorrhage

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W A Boykin, M. D.

, 19 (Address) 1512 Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lexington Va

DATE OF BURIAL 3/11 1930

20 UNDERTAKER Campbell Hensley

ADDRESS 598 N Bond

You desire to have this certificate filed, so that it may be a property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54931

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54931

CERTIFICATE OF DEATH

REGISTERED NO. 188-103

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) West Balto Hosp St. 16-68 Ward)

2-FULL NAME Yetta Genderson

(a) RESIDENCE NO. 327 Allison St. Wash D.C. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	M

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rubin Genderson

6 DATE OF BIRTH (month, day, and year) Don't Know 1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME [illegible] Kaufatzky

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Rachael Ann Kurt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Rubin Genderson
(Address) 1505 N Eutaw st.

Filed MAR 11 1930 JOHN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy (or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Thrown from auto in which she was riding when it was in collision with another

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract. Rib. Concussion Chest, Back Pelvis

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baker & Pulaski

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J J Hamm, M. D.

3/10, 1930 (Address) 2936 W Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Workmen Circle Cemetery

DATE OF BURIAL 3/11 1930

20 UNDERTAKER A. L. Levinson & Bro

ADDRESS 1127 E Balto st

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 54932 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 54932

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 E Lombard ST. 3-5 WARD)

2-FULL NAME Meyer Brill

(a) RESIDENCE NO. 1311 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Gertrude

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Brill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fakiel —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant By Brill (Address) 1311 E Lombard st

28 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11/30

17

I HEREBY CERTIFY, That I attended deceased from Dec, 1929, to Mar 11, 1930,

that I last saw him alive on March 6, 1930,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

and Hypertrophy

Chronic Myocardial Degeneration and

Fibrillation (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical + Laboratory Exam

(Signed) A. Blas, M. D.

March 11, 1930 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL Mar 11, 1930

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E. Balto st

TION is very important. See instructions on back of certificates.

MAR 11 1930 HAMPSON JONES, M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54933 — 13 V — E 54933

CERTIFICATE OF DEATH

REGISTERED NO. ____

1—PLACE OF DEATH Univ. Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard ST., ____ WARD) Apr 21 29

2—FULL NAME Mary Callahan

(a) RESIDENCE NO. 116 S. Sargent ST., ____ WARD ____ (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. 2 mos. 3 ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced — HUSBAND of (or) ~~WIFE of~~ Florence Callahan.

6 DATE OF BIRTH (month, day, and year) Jan 6th 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
39	♥	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O.P.

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Florence Callahan
(Address) 116 Sargent St

15 Filed APR 1 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/4/30

17 I HEREBY CERTIFY, That I attended deceased from 12/8/29, 19____, to 3/4/30 19____, that I last saw h[illegible] alive on 3/4/30, 19____, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cyanephrosis Bulatonal
Uremia
Pneumonia.
(duration) ____ yrs. ____ mos.

CONTRIBUTORY (Secondary) Pneumonia (duration) ____ yrs. ____ mos. 10 ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____, 19____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL 3/12/1930

20 UNDERTAKER John J. Cowan & Son

ADDRESS 401 Hollins St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54934

E 54934

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 6-9 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Oscar Millburn

(a) RESIDENCE NO. 1610 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 yr., hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Agricultural Chem Co

9 BIRTHPLACE (city or town) (State or country) Deale Island Maryland

PARENTS

10 NAME OF FATHER Francis Milburn

11 BIRTHPLACE OF FATHER (city or town) Deale Md (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Pollett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Mary Wright

(Address) 1742 Jefferson St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 8 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-13, 1930, to 3-8, 1930, that I last saw h[illegible] alive on 3-8, 1930, and that death occurred, on the date stated above, at 6 10 A m.

The CAUSE OF DEATH* was as follows:

Dislocation left shoulder -
Phlebitis right leg -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J Leyko, M. D.

3/8, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Deale Island Md

DATE OF BURIAL 3-11 1930

20 UNDERTAKER Mrs Edward H. Barley

ADDRESS 1721 Jefferson St

1930 [illegible] M. D.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54935

CERTIFICATE OF DEATH

101-001

E 54935

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 S. Madeira ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanislawa Waligorska.

(a) RESIDENCE NO. 206 S. Madeira ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. - mos. - ds. How long in U. S., if foreign birth? 28 yrs. - mos. - ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Waligorski.

6 DATE OF BIRTH (month, day, and year) Mar. 8 - 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	63	-	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) German
(State or country) Poland.

PARENTS

10 NAME OF FATHER — Weltsr.

11 BIRTHPLACE OF FATHER (city or town) German
(State or country) Poland.

12 MAIDEN NAME OF MOTHER — Zarnowska

13 BIRTHPLACE OF MOTHER (city or town) German
(State or country) Poland.

14 Informant Victor J. Waligorski Son
(Address) 206 S. Madeira St.

15 Filed APR 11 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9/30.

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 9, 1930

that I last saw him alive on March 9, 1930

and that death occurred, on the date stated above, at 6. A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P.S. & S.

(Signed) John V. Szurlicki M. D.

19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus.	Mar. 12. 1930

20 UNDERTAKER M. F. Sadowski. ADDRESS 2215 Pulaski Hy

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54936

CERTIFICATE OF DEATH

74001

REGISTERED NO. 54936

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 619 Jasper ST. 17-25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta Sophia Johnson

(a) RESIDENCE NO. 619 Jasper ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Perry Johnson

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co (State or country) Md

PARENTS

10 NAME OF FATHER John Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary E. Briggs

(Address) 619 Jasper St

15 Filed JUN 1 1930 C. HINCHMAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9-30

17

I HEREBY CERTIFY, That I attended deceased from 3-2-30, 19..., to 3-9-30, 19...

that I last saw h[illegible] alive on " , 19...

and that death occurred, on the date stated above, at 10 10 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. H. Carton, M. D.

, 19 (Address) 624 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL June 12, 1930

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 [illegible]

Spec.—1-30—M. & T.—250 Blks.

E 54937 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54937

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 16-37 WARD)

2-FULL NAME George Averle

(a) RESIDENCE NO. 4805 Fleet ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Averle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hipselman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed MAR 1 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10-30

17 I HEREBY CERTIFY, That I attended deceased from 9-4, 1929, to 3-10, 1930,
that I last saw him alive on 3-10, 1930,
and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of penis

(duration) Unknown mos. ..... da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 5 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Oct 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. H. Hampton M. D.

3-10, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 3/12 1930

UNDERTAKER John F. Connelly — ADDRESS Essex

SECTION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

2E 4704 54938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

122-001

E 54938

REGISTERED NO. 0-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Kenwood

(a) RESIDENCE NO. 628 S. Macon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George

6 DATE OF BIRTH (month, day, and year) Aug 3 - 1882

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	47	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Kriener Step Father

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9-30

17 I HEREBY CERTIFY, That I attended deceased from Mch 4, 1930, to Mch 9, 1930, that I last saw her alive on Mch 9, 1930 and that death occurred, on the date stated above, at 8 50 P m.

The CAUSE OF DEATH* was as follows:

cirrhosis of the liver with ascites

(duration) - yrs. 1 mos. - ds.

CONTRIBUTORY (Secondary) alcoholic delirium

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 628 S. macon St.

Did an operation precede death? yes Date of 3-5-1930

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Oskar Diethelm M. D.

3-9, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 3/12/1930

20 UNDERTAKER Wm. J. Connelly

ADDRESS Essex

important. See instructions on back of certificates.

MAR 1930 HAMPSON JONES, M. D.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

54939

31 E 54939

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 132 W. Hughes St.) (Ward) 22-31

2-FULL NAME William Conway

(a) **RESIDENCE NO.** 132 W. Hughes St. Ward 22

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Conway

6 DATE OF BIRTH (month, day, and year) Aug 20. 1886

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	43	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Samuel Conway

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Martha

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Emma Conway

(Address) 132 W Hughes St

Filed MAR 1 1930 HARRISON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/8 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/18, 1930, to 3/8, 1930, that I last saw h.. alive on 3/7, 1930, and that death occurred, on the date stated above, at 9.30A m.

The CAUSE OF DEATH* was as follows: Broncho-Pneumonia

(duration) ...yrs. ...mos. 21 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) ...yrs. ...mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) D. J. Connell, M. D.

3/10 1930 (Address) 830 Shawan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Blacknell Wlff Northumberland Va

Date of Burial 1930 3/12

20 UNDERTAKER A. S. Brown's Son

ADDRESS 108 N Monday St

Per 3 Reg Let S

very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

233566

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54940 X 49 ✓ E 54940

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Chillcott

(a) RESIDENCE NO. Southern Pines N Car ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 41 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances

6 DATE OF BIRTH (month, day, and year) Aug-28-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	6	11 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Thomas Chillcott

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Maria Flowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19 ... Registrar

APR 1 1930 C. HAMPSON REED, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March-11-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 30 19 30 to March 11 19 30

that I last saw h[illegible] alive on March 11 19 30

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

(duration) yrs. 2 hrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of Feb. 14, 1930

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) [signature], M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brookville, Pa	Jan 11 1930

20 UNDERTAKER C. Grant & Son 1180 Eutaw Place

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54941

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 E 54941

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 764 N Calvert ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Herrmann

(a) RESIDENCE No. 764 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Herrmann

6 DATE OF BIRTH (month, day, and year) Nov 24 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	3	13	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Eckhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edward Herrmann

(Address) 764 N Calvert

15 Filed MAR 1 1930 19 C. HAROLD WILLIS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 2, 1930, to Mar 8, 1930,

that I last saw her alive on Mar 8, 1930

and that death occurred, on the date stated above, at 10 25 p. m.

The CAUSE OF DEATH* was as follows:

"Senility" arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) angina pectoris

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual tests.

(Signed) George A Kunjap, M. D.

, 19 (Address) 3830 Edmondson Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL March 1, 19 30

UNDERTAKER Fred J Lechner & Son

ADDRESS Lan Ave

MAR 1 1930

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54942

CERTIFICATE OF DEATH

188-103

E 54942

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp. St. 18-26 Ward)

2-FULL NAME Wm McCloud

(a) RESIDENCE NO. 1009 N. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	21		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

PARENTS

10 NAME OF FATHER Thomas McCloud

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know
(State or country)

14 Informant Johnson Dickin
(Address) 1009 W. Fayette St.

Filed ... 1930 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/7/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows: While running around Lack of attention a bus struck deceased Caldwell him & Crushing him between car & bus Fracture

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Traumatic Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fayette & Gay

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) L. L. Crane M. D.

3/10, 1930 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount - R. 6. DATE OF BURIAL 3/11/30

20 UNDERTAKER Wm. H. Holland ADDRESS 631 Druid Hill Ave

Carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE TH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very tant. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54943

CERTIFICATE OF DEATH

74-001

E 54943

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH In front of home
City of Baltimore: (No. 2330 Washington Blvd St. (or Ward)

2-FULL NAME George W. Deems

(a) RESIDENCE NO. 2330 Washington Blvd St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence 1868

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer Md

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Geo. W. Deems

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Annie Kaufmann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Florence Deems
(Address) 2330 East Blvd.

15 Filed ....., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry.
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry find that said deceased came to death
(Inquest, autopsy or inquiry)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ..yrs. ..mos. ..da.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brownley, M. D.

3/10, 1930 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	3/13 1930
20 UNDERTAKER	ADDRESS
Edward Fowler	7357 Pulaski Hwy

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 11 1930

Spec.—1-31—M. & T.—250 Blks.

E 54944

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 54944

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (The) 3-12-20

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME Rose Venanzi

(a) RESIDENCE NO. 410 Glenn Edwards ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Venanzi

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Beganero

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Records (Address)

15 Filed MAR 11 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to March 10, 1930, that I last saw her alive on March 10, 1930, and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Shindel Jr. M. D.

3-10 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holly Redemption	3/13 1930
20 UNDERTAKER	ADDRESS
Gold Turner	1942 N Broadway

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54945

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54945

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS ST., 9-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., ... WARD .....

2-FULL NAME Mary Hilkins

(a) RESIDENCE NO. 1615 Asquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ? mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm R. Hilkins

6 DATE OF BIRTH (month, day, and year) ? 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) Md.

PARENTS

10 NAME OF FATHER Robt Marsh ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed MAR 11 1930 HARRY [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10-30

17 I HEREBY CERTIFY, That I attended deceased from 7-5, 1929, to 3-10, 1930, that I last saw her alive on 3-10, 1930, and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 5½ yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) over 6 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab

(Signed) Marvin M. Wilson, M. D.

3-10, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westburg Md

DATE OF BURIAL 3/13/1930

20 UNDERTAKER Robt J. Turner

ADDRESS 2452 N Broadway

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54946

CERTIFICATE OF DEATH

100-001

E 54946

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 238 N. Schroeder St. 18-76 Ward)

2-FULL NAME Jaiya C. Fisher

(a) RESIDENCE NO. 238 N. Schroeder St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 7, 1930

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Walter Fisher

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Gaynes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Elizabeth Gaynes
(Address) 238 N Schroeder

15 Filed 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows: Bronchio-Pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Bruba M. D.

3/5. 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 11, 1930
20 UNDERTAKER Mrs Kate R. Williams	ADDRESS 322 Schroeder St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 1 1930

Spec.—8-16-29—L. F. S.—100 M.a.

HEALTH DEPARTMENT—CITY OF BALTIMORE

54947

CERTIFICATE OF DEATH

100-001 E 54947

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 S. Ellwood Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME [redacted] Marie Grabowski

(a) RESIDENCE NO. 1232 S. Ellwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Jan 27th 1929

7 AGE: Years 1 | Months 1 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Philip Grabowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Josephine Krzywicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Philip Grabowski

(Address) 1232 S. Ellwood Ave

15 MAR 11 1930 H. A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4th, 1930, to March 9th, 1930, that I last saw h[illegible] alive on March 9, 1930 and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ezekiel N Kelley, M. D.

March 9th, 1930 (Address) 100 S. Patterson Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: March 11 1930

UNDERTAKER: Stephen J. Falkowski

ADDRESS: 1610 E. Monument

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54948 118-002 E 54948

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital ST. 17-24 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2—FULL NAME Eleanor Gant

(a) RESIDENCE NO. 538 W Biddle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/11/02

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Sam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Chandler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hosp Records — (Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-7-30

17 I HEREBY CERTIFY, That I attended deceased from 3-7, 1930, to 3-7, 1930, that I last saw her alive on 3-7, 1930, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date Hysterectomy 2/9/30 Exploratory 2/15/30

Was there an autopsy?

What test confirmed diagnosis Clinical + Operative

(Signed) J. Leyko, M. D.

3/7, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lutherville DATE OF BURIAL 3/10/30, 19

UNDERTAKER Samuel J. Hemsley 1538 W Baltimore

Commissioner of Health

important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND MAR 11 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54949

CERTIFICATE OF DEATH

31 E 54949

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N. Curley ST. 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes E. Rolfes.

(a) RESIDENCE NO. 711 N. Curley ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman H. Rolfes.

6 DATE OF BIRTH (month, day, and year) Mch. 11th 1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
44	11	28 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Emanuel Dotorels

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Marie Janke

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Herman H. Rolfes.
(Address) 711 N. Curley St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 10th 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/1, 19 30, to 3/10, 19 30, that I last saw her alive on 3/9/30, 19.... and that death occurred, on the date stated above, at 2 30 a.m. The CAUSE OF DEATH* was as follows:

Pulmonary T B

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 711 N. Curley

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

3/11, 1930 (Address) 2939 W. Oden Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Mch 13th 1930

20 UNDERTAKER Lilly & Sons Inc.

ADDRESS 400 E. Mt. [illegible]

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54950

CERTIFICATE OF DEATH

31 E 54950

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1012 S. Clinton ST., 26-1 WARD)

2—FULL NAME J. Peter Bauernschub

(a) RESIDENCE NO. 1012 S. Clinton ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth H. Bauernschub

6 DATE OF BIRTH (month, day, and year) March 16th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George J. Bauernschub

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth H. Bauernschub

(Address) 1012 S. Clinton St.

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/9/30

17 I HEREBY CERTIFY, That I attended deceased from January 12, 1930, to March 9, 1930, that I last saw him alive on March 8, 1930, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jos. A. Rosenblatt, M. D.

3/9, 1930 (Address) 3018 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 12 1930
20 UNDERTAKER Lilly & Julian Inc.	ADDRESS 700 E. Mulberry St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54951

CERTIFICATE OF DEATH

129 E 54951

REGISTERED NO.

1—PLACE OF DEATH Md. General Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 18-29 ST., Cordus WARD)

2—FULL NAME Mrs. Mabel Cordus

(a) RESIDENCE NO. 16 S. Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of George J. Cordus

6 DATE OF BIRTH (month, day, and year) 1/15/1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) York (State or country) Penna.

PARENTS

10 NAME OF FATHER Henry Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Alice Lucinda Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Hospital Records (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/30

17 I HEREBY CERTIFY, That I attended deceased from 2/15, 1930, to 3/11, 1930, that I last saw h[illegible] alive on 3/11, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular-renal disease (duration) Known 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) [signature] M. D.

3/14, 19 (Address) [signature]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Mar. 13 1930

20 UNDERTAKER [signature]

ADDRESS 1003 West Baltimore St.

C. HAMPSON JONES, M. D.

MAR 14 1930

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54952

CERTIFICATE OF DEATH

REGISTERED NO. 129 E 54952

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 West Fayette ST., 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa M. Moore

(a) RESIDENCE NO. 1531 West Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Moore

6 DATE OF BIRTH (month, day, and year): Aug. 15th 1868

7 AGE: Years 61 | Months 6 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At home

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John Foerster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Henrietta Brodhaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Rita Walker

(Address) 1531 West Fayette St.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 10th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1930, to Mar. 10, 1930, that I last saw her alive on Mar. 10, 1930 12 Noon and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Infiltration of Nephritis.

CONTRIBUTORY (Secondary) Mitral Regurgitation (duration) 3 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam

(Signed) Chas. Norton, M. D.

3/10/30 (Address) 888 West Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: Mar. 13, 1930

20 UNDERTAKER: Joseph L. Cook

ADDRESS: 1003 N. Dallas St.

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54953 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 90 E 54953

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 16-37 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lyons

(a) RESIDENCE NO. Balto. City Hospitals ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Clinton

(State or country) Md.

PARENTS

10 NAME OF FATHER Timothy Lyons

11 BIRTHPLACE OF FATHER (city or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Helen Ronan

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Records of Balto. City Hospitals

(Address)

15 Filed MAR 11 1930, 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-20-24, 19 ..., to 3-9-30, 19 ..., that I last saw him alive on 3-9-30, 19 ..., and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marion McVee Lane, M. D.

3-10, 19-30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL March 12, 1930

20 UNDERTAKER Wm. E. McCleaf & Son — ADDRESS 501 E 28th St.

CAUSE OF DEATH IS VERY important. See instructions on back of certificates.

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 54954

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54954

CERTIFICATE OF DEATH.

16

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 W 40th St ST. 13-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sally Wethered Carroll

(a) RESIDENCE NO. 519 W 40th St ST., WARD

(Usual place of abode) (If non-resident give city, or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19th 1840

7 AGE: Years 89 | Months 6 5 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Fudlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass.

14 Informant Miss Fedlow Carroll Willett

(Address) 519 W 40th St

15 Filed MAR 11 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10th 1930

17

I HEREBY CERTIFY, That I attended deceased from March 5, 1930, to March 10, 1930, that I last saw her alive on March 9, 1930, and that death occurred, on the date stated above, at 5-45 P. m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary hypostasis about

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jas. H. Creighton, M. D.

March 11, 1930 (Address) 1800 N. Charles St. Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old St Paul Cem — DATE OF BURIAL: March 12 1930

20 UNDERTAKER: Henry Jenkins & Son — ADDRESS: Edward Jenkins Baltimore

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54955

CERTIFICATE OF DEATH

18 SE 54955

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Sinai Hospital St. 13-59 (Ward)

2-FULL NAME Rachel Lewyt

(a) RESIDENCE NO. 2327 Eutaw Place. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany. 4th. 1846

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	84	2	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Solomon H. Lewyt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Holland

12 MAIDEN NAME OF MOTHER Sarah Leon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Holland

14 Informant Mrs. Charles Hirsch
(Address) Lake Drive Apts.

15 Mar 11 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure-Senility
Fractured left (neck) Femur-(2 mons)
Accidently fell in bed room at home

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Xray etc

(Signed) [signature], M. D.

3/11/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Baltimore Hebrew Cem.

DATE OF BURIAL 3/ 12/ 1930

20 UNDERTAKER Harry Sondheim

ADDRESS 118-20 W. Mt. Royal Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R1

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54956

CERTIFICATE OF DEATH

41 E 54956

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 27-44 Ward

2-FULL NAME Fred A. Rouse

(a) RESIDENCE NO. 2313 Hamilton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Rouse

6 DATE OF BIRTH (month, day, and year) Aug 11/1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	51	7 6	25 27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chief Appraiser
(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Customs
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Rudolph Rouse

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Rudolphe E. Rouse
(Address) 2313 Hamilton Ave

15 Filed ..., 19.. Registrar

R 1 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia-(Streptococcic)

Infected teeth extracted 3 days before

(duration) ..yrs. ..mos. ..da.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

3/11/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 3/12 1930

20 UNDERTAKER Geo J. Ruth — ADDRESS 1735 Hanford Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54957

CERTIFICATE OF DEATH

90 E 54957

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1720 St Paul St. St. 12-19 Ward)

2-FULL NAME Colin Reid Campbell.

(a) RESIDENCE NO. 1720 St. Paul St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. --- mos. --- da. How long in U. S., If of foreign birth? 15 yrs. --- mos. --- da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of ~~XXX WIFE of~~ Annie Campbell.

6 DATE OF BIRTH (month, day, and year) October 8th. 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	73	5	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired Broker.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Scotland.
(State or country)

PARENTS

10 NAME OF FATHER William Campbell.

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Scotland.

12 MAIDEN NAME OF MOTHER Martha Reid.

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Scotland

14 Informant Jane Campbell. (daughter)
(Address) 1720 St. Paul St.

15 Filed ..., 19... Registrar

R 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.
Acute dilatation of the Heart.

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

3/10, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	3/12, 1930
UNDERTAKER	ADDRESS
Henry W. Means Son.	705 N. Calvert

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54958

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54958

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elvista Drummond

(a) RESIDENCE NO. 16 18 Ettting ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10-1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	—	29 29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Grover Drummond

11 BIRTHPLACE OF FATHER (city or town) (State or country) S Car

12 MAIDEN NAME OF MOTHER Mamie Guest

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9-1936

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 9, 1930, that I last saw her alive on March 9, 1930 and that death occurred, on the date stated above, at 915 P m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart Disease

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. O. Wood, M. D.

3/10, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn

DATE OF BURIAL 3/12/1930

UNDERTAKER Geo. H. Holland

ADDRESS Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

St Magnus 1206 E Preston St

E 54959

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54959

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4025 Bellwood Ave WARD 27-41

2-FULL NAME Mary Gladys Ferguson

(a) RESIDENCE NO. 4025 Bellwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 5/20/1907

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
22	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer) " " 086

(c) Name of employer

9 BIRTHPLACE (city or town) Washington (State or country) D.C.

PARENTS

10 NAME OF FATHER Edward C Ferguson

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D.C.

12 MAIDEN NAME OF MOTHER Catherine C Henkel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Catharine C Henkel (Address) 4025 Bellwood ave

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

R 1 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/30

17 I HEREBY CERTIFY, That I attended deceased from 3/1, 1930, to 3/10, 1930, that I last saw her alive on 3/10, 1930, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ? yrs. ? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of none

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) S. Lee Magnus M. D.

3/11, 1939 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 3/13/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Katzenberger

E 54960 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54960

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2229 West Lexington ST. (WARD) 9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia E. Towers

(a) RESIDENCE NO. 2229 West Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John Towers

6 DATE OF BIRTH (month, day, and year) June 20/44

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85	9 8	8 19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James H. Amich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sophia Jarvis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary E Lotz

(Address) 2229 West Lexington

15 Filed APR 1 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9-1930

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to March 9, 1930, that I last saw h[illegible] alive on March 8, 1930, and that death occurred, on the date stated above, at 9 18 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis, Chronic Appendicitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) [illegible] M. D.

3/10 1930 (Address) 1779 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/12 1930

UNDERTAKER William Cook

ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CASE IS VERY important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Dr. Kyser 4900 Fredrick Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54961

CERTIFICATE OF DEATH.

10 E 54961

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4111 Walrad Ave (ST.) 20-71 (WARD)

2-FULL NAME Gordon K. Chappell

(a) RESIDENCE NO. 4111 Walrad Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mabel O.

6 DATE OF BIRTH (month, day, and year) 2/22/1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Courtlins Chappell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Daley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant W. W. Sears

(Address) 2511 W. Lanvale st.

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1930, to Mar 10, 1930, that I last saw him alive on Mar 10, 1930 and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Fd interstinous pleurisy

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) J T Kyser, M. D.

, 19 (Address) 3321 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetary — DATE OF BURIAL 3/13/1930

20 UNDERTAKER Wm Cook — ADDRESS 127 St Paul st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occ. TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54962

CERTIFICATE OF DEATH.

89 E 54962

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2604 Garrison Blvd ST. 15-61 WARD)

2-FULL NAME Arthur Edwards Warner

(a) RESIDENCE NO. 2604 Garrison Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice L Warner

6 DATE OF BIRTH (month, day, and year) June 14-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Off

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Provident Mutual

9 BIRTHPLACE (city or town) Lincoln

(State or country)

PARENTS

10 NAME OF FATHER Charles E Warner

11 BIRTHPLACE OF FATHER (city or town) Lincoln

(State or country) Va

12 MAIDEN NAME OF MOTHER Caroline Sawnner

13 BIRTHPLACE OF MOTHER (city or town) Lincoln

(State or country) Va

14 Informant Alice L Warner

(Address) 2604 Garrison

15 Signature H. A. JONES, M. D. Registrar

MAR 12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar-10-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar-10, 1930, to , 19 ,

that I last saw him alive on Mar-10, 1930,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical Symp.

(Signed) Wesley Cole, M. D.

19 (Address) 2202 Harvin Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lincoln Va

DATE OF BURIAL Mch 12 1930

20 UNDERTAKER W. Redmond Inc

ADDRESS Norfolk Va

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

54963

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-801 E 54963

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3209 Piedmont Ave 165-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna b. Smith

(a) RESIDENCE NO. 3209 Piedmont Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ferdenand b Smith

6 DATE OF BIRTH (month, day, and year): Feb 28 1850

7 AGE: Years 80 Months 0 Days 10

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Emil Haberkam

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Ferdenand b Smith

(Address) 3209 Piedmont Ave

15 Filed MAR 12 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 10-1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 8, 1930, to Mch 10, 1930, that I last saw h. er alive on Mch 9, 1930, and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

36 hours

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Hemiplegia

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. S Parker M. D.

, 19 (Address) 3128 W Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Mar 12 30

20 UNDERTAKER: Wm J Tickner Sons

ADDRESS: N. Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 54964

E 54964

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 211-E Lafayette ST. 17-14 WARD)

2—FULL NAME Carrie Rebecca Sauner

(a) RESIDENCE NO. 211-E Lafayette ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 0 mos. 17 ds. How long in U. S., if foreign birth 61 yrs. 0 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo W Sauner

6 DATE OF BIRTH (month, day, and year): Feb 22nd 1869

7 AGE: Years 61 | Months 0 | Days 14 17 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Aaron Snaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah Kimble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Miss Eva Grace Sauner (Sister)
(Address) 211-E Lafayette St.

15 Filed MAR 12 1930, HARRY M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch. 11. 30.

17 I HEREBY CERTIFY, That I attended deceased from Mch 11, 1930, to Mch 11, 1930, that I last saw h[illegible] alive on Mch. 11, 1930, and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease
(Mitral Regurgitation)
(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. P. Strong M. D.

. 19 (Address) 506 Hanover st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Mar. 13 1930

20 UNDERTAKER: Clement Mowbray — ADDRESS: Balto

Be sure that all items are answered fully, so that it may be properly classified. Exact statements important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 54965 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓ E 54965

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1705 Park Ave ST. 14-20 (WARD)

(REGISTERED NO.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eldridge Cowman Price

(a) RESIDENCE NO. 1705 Park Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 76 yrs. 0 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. L. Price

6 DATE OF BIRTH (month, day, and year) Feb 21 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	76	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Medicine

(c) Name of employer Self Balto. Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Dr. E. C. Price Balto. Co.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha G. Cowman

13 BIRTHPLACE OF MOTHER (city or town) Alexandria (State or country) Virginia

14 Informant Mrs Mary L. L. Price (wife)

(Address) 1705 Park Ave

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6-, 1930, to March 10-, 1930

that I last saw him alive on March 10-, 1930

and that death occurred, on the date stated above, at 8:55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas, Probably some liver involvement.

abt (duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) chronic interstitial nephritis

(duration) Hist. about 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical -

(Signed) Edward Powers, M. D.

3/11, 1930 (Address) 212 S. Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Mar 17 1930
20 UNDERTAKER	ADDRESS
Edward H. Moser Co.	Balto.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54966

CERTIFICATE OF DEATH

101-001

E 54966

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp St. 13-51 Ward)

2-FULL NAME Eugene S Tucker.

(a) RESIDENCE NO. 840 W. 32nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Virginia

6 DATE OF BIRTH (month, day and year): Feb 16 1863

7 AGE: Years 67 | Months 0 | Days 22 24 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: John Tucker

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Emma Smith

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Laurence Tucker
(Address): 3032 Windsor

15 Filed DEC 2 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Nov 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Regular

(Signed) H. C. Funk, M. D.

(Address) Md 12/9/30 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Center M. E Church Forest Hill Harford Co Md — DATE OF BURIAL: 12/2 1929

20 UNDERTAKER: L. P. Fussellbaugh — ADDRESS: 2620 St Paul

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54967

CERTIFICATE OF DEATH

170 ✓ E 54967

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Druid Apts 5-8- St. 13-59 Ward)

2-FULL NAME Maurice Amansky

(a) RESIDENCE NO. Druid Apts. 5-8- St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa

6 DATE OF BIRTH (month, day, and year) Dec 8 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	45	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing
(b) General nature of industry, business, or establishment in which employed (or employer) Mfg
(c) Name of employer

9 BIRTHPLACE (city or town) Warsaw
(State or country)

PARENTS

10 NAME OF FATHER Pasah Amansky

11 BIRTHPLACE OF FATHER (city or town) Warsaw
(State or country)

12 MAIDEN NAME OF MOTHER Goldie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Warsaw

14 Informant Harry Bransky
(Address) 244 E Lafayette Ave

15 Filed ..., 19.. C. HANSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1931

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide

Gun Shot of Chest. (Bowlers)

(duration) ..yrs. ..mos. — ds.

CONTRIBUTORY Shock
(Secondary)

(duration) ..yrs. ..mos. — ds.

18 Where was disease contracted — —
If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? — Of —

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem	3/12 1930
20 UNDERTAKER Sol Levinson & Bro	ADDRESS 1217 E Balto St

MAR 2 1930

IMPORTANT: WRITE CLEARLY INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54968

CERTIFICATE OF DEATH.

38 E 54968

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 805 N. Carey (St.) 16-23 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Henderson

(a) RESIDENCE NO. 805 N. Carey St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2-4-1895

7 AGE: Years 35 | Months 1 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rachel Barney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Agusta Scott 805 N. Carey St

15 Filed MAR 18 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 - 11 - 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-3-, 1930, to 3-11-, 1930.

that I last saw h[illegible] alive on 3-11-, 1930

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cardio Renal Vascular disease

CONTRIBUTORY (Secondary) Syphilis (Tertiary) (duration) 6 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. C. Page M. D.

, 19 (Address) 1516 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: Mar 15 1930

20 UNDERTAKER: Wm. E. Widdifield Son Company

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 54969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 54969

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 N Boyd ST. 7-9 WARD)

2-FULL NAME Sarah M Bakins

(a) RESIDENCE NO. 536 N Boyd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): about 1875

7 AGE: Years: about 55 Months: Days: If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Canada

PARENTS

10 NAME OF FATHER: Chas Aikins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Harriett Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Emma Herrmann (sister)
(Address): 536 N Boyd

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

MAR 12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 10 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb ..., 1930 ..., to March 10, 1930,

that I last saw he alive on March 8, 1930

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Insufficiency
(Endocarditis)

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis, Enlarged Liver and General Anasarca

(duration) ... yrs. 2 mos. ... da.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. F. Young, M. D.

3/11, 1930 (Address) 1429 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn Cemetery

DATE OF BURIAL: Mar 12 1930

20 UNDERTAKER: Lottie Grosa

ADDRESS: 1403 Ashland Ave

Cor.—10-10-29—A Co.—100 Bks.

54970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 54970

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2011 Madison Ave St.) 4-20-30

2-FULL NAME Elizabeth Lynn

(a) RESIDENCE NO. 2011 Madison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day and year): 1898

7 AGE: Years 32 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook.
(b) General nature of industry, business, or establishment in which employed (or employer): Ot
(c) Name of employer

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): unknown

14 Informant: Lillie Dorsey
(Address): 2011 Madison Ave

15 Filed ....., 19.... City Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): March 10th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Th F. H. Luck, M. D.

March 19 30 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: March 20 19 30

20 UNDERTAKER: Samuel E. Staub

ADDRESS: W. Balto

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

FILLING IN BLANKS, WITH UNDERLINING INK—THIS IS A PERMANENT RECORD.

E 54971

HEALTH DEPARTMENT—CITY OF BALTIMORE E 54971

CERTIFICATE OF DEATH.

87

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 747 Poplar Grove ST. 16-68 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Elizabeth Boyce

(a) RESIDENCE No. 747 Poplar Grove ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced (Husband) of or) WIFE of Wm Boyce

6 DATE OF BIRTH (month, day, and year) Aug 30, 1859

7 AGE Years 70 Months 6 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Celia Daren

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph B Simpline

(Address) 747 Poplar Grove

15 Filed MAR 2 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 27, 1930, to March 11, 1930, that I last saw her alive on March 10, 1930, and that death occurred, on the date stated above, at 7.20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D. Neyle M.D.

3/11, 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mar 14, 1930

20 UNDERTAKER Josiah Ayler — ADDRESS 1600 W Lex

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54972

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

E 54972

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 318 N. Strieker St. 14-27 Ward)

2-FULL NAME Robert Marbarrow

(a) RESIDENCE NO. 318 N. Strieker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1, 1929

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	6	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas Marbarrow

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Richmond, Va

12 MAIDEN NAME OF MOTHER Myrtle Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Howard Co. Md

14 Informant Mr. Chas. Marbarrow
(Address) 318 N Strieker St

15 Filed MAR 12 1930 C. HUGHLETT JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said I (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Brien M. D.

3/11 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	3/12 1930
20 UNDERTAKER Mrs. Katie R. Hellhamm	ADDRESS 322 N Schroeder

PRINT CLEARLY, WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 54973

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54973

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH Sinai Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Smith

(a) RESIDENCE NO. 517 N. Wolfe ST. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A. Smith

6 DATE OF BIRTH (month, day, and year): Nov 7/1850

7 AGE — Years: 79 — Months: 4 — Days: 3 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oven

(b) General nature of industry, business, or establishment in which employed (or employer): Builder

(c) Name of employer: Himself

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: — Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Alvin Smith (Address) 517 N. Wolfe St

15 Filed . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/17 19 30

17 I HEREBY CERTIFY, That I attended deceased from 2-7, 19 30, to 3-10, 19 30, that I last saw him alive on 3-10, 19 30, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Several years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes, atherosclerosis, hypertension, myocardial failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & lab.

(Signed) A. A. Sinai, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Mar 13/30

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ARE TRUE. C. HARRISON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

E 54974 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 54974

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4847 Park Heights Ave. ST. 27-56 (WARD)

2-FULL NAME Mary Bertha Kyper

(a) RESIDENCE NO. 4847 Park Heights Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William A. Kyper

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER William Krause

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Mitler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant William A. Kyper
(Address) 4847 Park Heights Ave.

15 Filed 19 Registrar

MAR 12 1930 HAMILTONS M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 7, 19 to Mch 11 19 30,
that I last saw her alive on Mch 11 19 30,
and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis, Complicated by Apoplexy, Cerebral Hemorrhage,

(duration) 2 yrs. ds.

CONTRIBUTORY (Secondary) Cardio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Mar. 13 19 30

20 UNDERTAKER: John O. Mitchell & Sons, — ADDRESS: 1900 Eutaw Pl

John O. Mitchell & Sons

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54975

CERTIFICATE OF DEATH

31 ✓ E 54975

1—PLACE OF DEATH

REGISTERED NO. 7160 15

CITY OF BALTIMORE: (No. 1219 Greenmount Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Harvey

(a) RESIDENCE NO. 1219 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 64 yrs. — mos. ds. How long in U. S., if foreign birth? N.A. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John. E. Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine O'Callahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Margaret Fetter

(Address) 1219 Greenmount Ave

MAR 12 1930 Filed C. HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 10 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/1, 1930, to 3/10, 1930, that I last saw h[illegible] alive on 3/9/30 1930 and that death occurred, on the date stated above, at 7:50 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

? ? ?

(duration) 0 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) S. Lee Maguess, M. D.

3/11, 1930 (Address) 1706 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	March 13, 1930
20 UNDERTAKER Henry Hoen & Sons, Inc.	ADDRESS 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Unbrich
704 Cathedral St

E 54976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 54976

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2609 E. Oliver ST. 8-16 WARD)

2-FULL NAME John B. Voit

(a) RESIDENCE NO. 2609 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Voit

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Motorman

(b) General nature of industry, business, or establishment in which employed (or employer) 078

(c) Name of employer United R.R.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Voit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary A. Voit (Address) 2609 E. Oliver St.

15 Filed MAR 12 1930 19 .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1930, to March 11, 1930, that I last saw him alive on March 11, 1930, and that death occurred, on the date stated above, at 11 1/2 a.m.

The CAUSE OF DEATH* was as follows:

(1) Pneumonia abscess

(2) Adenitis cervical

(3) Thrombosis Jugular - R (2) 3

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Anemia secondary.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Germany

(Signed) J. Stanley Clemens, M. D.

Mar. 30 (Address) 704 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Mar. 15 1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 N. Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

54977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

17° E 54977

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. West Balto Gen Hosp St.) 15-60 (Ward)

2-FULL NAME Chas E. Tolson.

(a) RESIDENCE NO. 2820 Windsor St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen R.

6 DATE OF BIRTH (month, day and year) Sept 9-1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40	7	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance Agent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Metro Life Ins Co

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Wesley Tolson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Tyler Davidson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Helen Tolson
(Address) 2820 Windsor Ave

15 Filed MAR 21 1930 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 11th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Hemorrhage due to pistol wound of brain (duration) ..... yrs. Instant

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Inquest

(Signed) H. B. Leitch, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 3/14/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

NOTICE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54978

CERTIFICATE OF DEATH.

129 E 54978

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 432 E Clement ST. 24-33 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Cardeau

(a) RESIDENCE NO. 432 E Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L Cardeau

6 DATE OF BIRTH (month, day, and year) Feb 20-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways Co

9 BIRTHPLACE (city or town) (State or country) Nova Scotia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant John J. Cardeau (Address) 425 Eclmont

MAR 12 1930

G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 10 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930, to Mar. 10, 1930, that I last saw him alive on Mar. 10, 1930, and that death occurred, on the date stated above, at 1245 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis + Chronic Endocarditis

(duration) yrs. annual mos ds.

CONTRIBUTORY (Secondary) Uraemia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Lt Bunglass M. D.

3/10, 1930 (Address) 301 E Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. DATE OF BURIAL 3/13/30

20 UNDERTAKER J J Daley & Sons ADDRESS 1318 Light

Information, to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 54979 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54979

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No.) ST. (OR WARD) 18-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Newman

(a) RESIDENCE NO. 248 Bowers st. ST., WARD

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rose Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed APR 12 1930. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 19 30, to March 7, 19 30, that I last saw him alive on March 7, 19 30, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

3-8, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAN

DATE OF BURIAL MAR 12 1930

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-
TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54980

24 V E 54980

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 Collins Ave., ST. 70-7 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Dunnock

(a) RESIDENCE NO. 503 Collins Ave., ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Jesse L. Dunnock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary Hayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jesse L. Dunnock
(Address) 503 Baltimore

15 Filed MAR 12 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4th, 19 30, to March 12th, 19 30

that I last saw her alive on March 12th, 19 30

and that death occurred, on the date stated above, at 10 A.m.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cumberland M. D.

3/12 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Bethel	March 13 1930
20 UNDERTAKER	ADDRESS
M. W. & Dippold	27 S. Gay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 54981

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54981

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 N. Dallas St. 8-13 WARD)

2-FULL NAME John H. Howard

(a) RESIDENCE NO. 1222 N. Dallas St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Howard

6 DATE OF BIRTH (month, day, and year) Feb 15 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54 year	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fayetteville N C

PARENTS

10 NAME OF FATHER John H Howard

11 BIRTHPLACE OF FATHER (city or town) Fayetteville (State or country) N C

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fayetteville N C

14 Informant Wife Eliza Howard (Address) 1212 N Dallas St

15 Filed R 1 2 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4 - 1929 to Mar. 10 - 1930, that I last saw h[illegible] alive on Mar. 8 - 1930, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) — yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

3/11/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 3/13 1930

20 UNDERTAKER Rayner Sanders 1515

ADDRESS Millemen St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 54982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54982

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2826 Parkwood Ave. ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George P. King

(a) RESIDENCE NO. 2826 Parkwood Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced
BUSBAND of (or) WIFE of Virginia C. King

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	15	17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob King

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Ernestine VonTelnagle

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14
Informant Miss Edna Mae King
(Address) 2826 Parkwood Ave.

15
Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1930

17
I HEREBY CERTIFY, That I attended deceased from Sept. 1929 to March 12 1930,
that I last saw him alive on March 10, 1930
and that death occurred, on the date stated above, at 7.52 A.M.
The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(duration) 6 yrs. mos. da.

CONTRIBUTORY (Secondary) arterio-sclerosis

(duration) 15 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis Whitehorne M. D.

3/12 1930 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Loudon Park Cemetery

DATE OF BURIAL
Mar. 14 1930

20 UNDERTAKER Joseph L. Cook

ADDRESS
1003 West Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54983

CERTIFICATE OF DEATH

31 E 51983

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2119 Maryland Ave. ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah J. Currie

(a) RESIDENCE NO. 2119 Maryland Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of James M. Currie

6 DATE OF BIRTH (month, day, and year) Feb. 26, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	-	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mount Pleasant Mississippi

PARENTS

10 NAME OF FATHER Edward L. Jones

11 BIRTHPLACE OF FATHER (city or town) Marshall County (State or country) Mississippi

12 MAIDEN NAME OF MOTHER Martha Brittenum

13 BIRTHPLACE OF MOTHER (city or town) Mt. Pleasant (State or country) Mississippi

14 Informant Mr. R. Turner Currie

(Address) 2119 Maryland Ave.

15 Filed ____, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to March 10th, 1930, that I last saw her alive on March 10th, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) General kidney Tuberculosis with uremic infection (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination.

(Signed) Robert L. Armistead, M. D.

3/11, 1930 (Address) 2112 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
All Saints P. E. Cemetery Reisterstown, Md.	Mar. 12th 30
20 UNDERTAKER Wood & Cook	ADDRESS 1003 West Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

MAR 21 1930 C. HAMPSON JONES, M.D.

Spec.—1-30—M. & T.—250 Blks.

E 54984

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54984

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 19-27 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Saums

(a) RESIDENCE NO. 341 N. Stricker St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 19, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Christian C. Saums

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Emma J. Clautice

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed MAR 12 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-30

17 I HEREBY CERTIFY, That I attended deceased from 3-4-30, 19, to 3-12-30, 19,

that I last saw her alive on 3-12-30, 19,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. over 9 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) yrs. over 9 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren M. McLean, M. D.

3-12, 19-30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Mar. 14 19 30

20 UNDERTAKER Joseph J. Cook

ADDRESS 1003 West Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 12 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54085 X 129 E 54085

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Smith

(a) RESIDENCE NO. Woodstock College Md ST., WARD Woodstock, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER Louis Smokeys

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Judith Kaublicka

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Hospital Records
(Address)

15 Date received MAR 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/30

17 I HEREBY CERTIFY, That I attended deceased from 12/27/29, 19..., to 3/11/30, 19..., that I last saw h[illegible] alive on 3/11/30, 19..., and that death occurred, on the date stated above, at 4 20 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio Vascular Renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) David Jones, M. D.

3/11/30 19 (Address) Mercy Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodstock Md Cemetery — DATE OF BURIAL 3-13-1930

UNDERTAKER Bernard C. Harke 1000 — ADDRESS S Paca St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-30—M. & T.—350 Blks

Ac Scott 4815 Washington Ave Brooklyn (Curtis 0209

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54986

CERTIFICATE OF DEATH.

n5-001 6

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1724 Webster ST. 74-24 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Von Eulin

(a) RESIDENCE No. 1724 Webster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Von Eulin

6 DATE OF BIRTH (month, day, and year) Aug. 10 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician 029

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Elec. Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newark City, Delaware

PARENTS

10 NAME OF FATHER Mathew Von Eulin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Frank Von Eulin

(Address) 1724 Webster Street

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11/1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1929 to Mar. 11, 1930, that I last saw him alive on Mar. 11, 1930 and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia

(duration) 1 yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

Mar 17, 1930 (Address) 1615 Pennington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 3/14 1930

20 UNDERTAKER William Cook

ADDRESS 127 S. Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of MODE OF DYING, and of DISEASE or CONDITION is very important. See instructions on back of certificates.

MAR 14 1930

Form

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54987

CERTIFICATE OF DEATH

11 E 54987

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1627 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Donnell

(a) RESIDENCE NO. 1915 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Alma Donnell

6 DATE OF BIRTH (month, day, and year) 12/29/11

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Loader

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y. State.

PARENTS

10 NAME OF FATHER Wm Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York State

12 MAIDEN NAME OF MOTHER Mary Bryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y. State.

14 Informant Hospital Records

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

AR 1 2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/30

17 I HEREBY CERTIFY, That I attended deceased from 2/27, 1930, to 3/11, 1930, that I last saw him alive on 3/11, 1930 and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Infarction (?) Stroke (?)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

Surgical Shock (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes - appendectomy. Date of 3/3/30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm H. McFaul Jr, M. D.

, 19 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ticonderoga N. Y.

DATE OF BURIAL 3/13 1930

UNDERTAKER William Cook

ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Barker

E 54988 HEALTH DEPARTMENT—CITY OF BALTIMORE E 54988

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 Longwood ST. 15-67 WARD)

2-FULL NAME Isabelle T. Barker.

(a) RESIDENCE NO. 1910 Longwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Oct. 8, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59.	5.	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk. No

(b) General nature of industry, business, or establishment in which employed (or employer) Federal Reserve

(c) Name of employer Bank.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William C. Barker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Frances Barron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England.

14 Informant Elizabeth Barker.

(Address) 1910 Longwood St.

15 Filed MAR 21 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11-1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 23, 1929, to Mar-11-, 1930, that I last saw her alive on Mar-9-, 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency with Myocardial insufficiency & decompensation

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Auto Collision —

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wesley Cole, M. D.

3/12, 1930 (Address) 1701 Bolton.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	March 13 1930
20 UNDERTAKER	ADDRESS
A. H. and E. Evans	28 E. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54989 ✓ E 54989

CERTIFICATE OF DEATH

REGISTERED NO. 25-72 112

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1614 Harmon ave St., 25 Ward)

2-FULL NAME Elizabeth Allied

(a) RESIDENCE NO. 1614 Harmon ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry

6 DATE OF BIRTH (month, day and year) Sept 20 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	68	5	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work W. W.
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) York Pa
(State or country)

PARENTS

10 NAME OF FATHER John Kahline

11 BIRTHPLACE OF FATHER (city or town)
(State or country) York Pa

12 MAIDEN NAME OF MOTHER Martha Walters.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Geo. Elliott
(Address) 1614 Harmon ave

15 Filed MAR 12 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooks M. D.

3/12. 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	March 14 1930

20 UNDERTAKER Bernard A. Finke ADDRESS 734 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54990 78 E 54990

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto Md ST. 17-25 WARD)

2—FULL NAME Joseph Liberto

(a) RESIDENCE NO. 412 N Greene St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-16-1911

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
18	19	3	24 23	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Liberto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown Maria Bracato

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy Unknown

14 Informant Records Balto City Hosp.
(Address)

15 Filed ... 19 ... H. LINDSAY JONES, M. D. Registrar

MAR 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9-30

17 I HEREBY CERTIFY, That I attended deceased from 3-9-, 19 30, to 3-9-, 19 30; that I last saw h(im/er) alive on 3-9-, 19 30 and that death occurred, on the date stated above, at 9 46 P. m.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Thy occasional Sorbine

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Amy Goldsmith M. D.

3/10 19 30 (Address) Baltimore City Hosps.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 3/13/30 19

20 UNDERTAKER George J. Puth

ADDRESS 1735 Harford Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 54991 — 181 — Vol

E 54991
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St 3-5 Ward)

2-FULL NAME Egnatz Shoulklis.

(a) RESIDENCE NO. 80 Albemarle St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. —mos.—ds. How long in U. S., if of foreign birth 27 yrs.—mos.— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	51	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Adam Urban.
(Address) 80 Albemarle St.

15 Filed MAR 3 1930 HARRISON JONES, M. D. Registrar
Per Klee

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia, Pulmonary Oedema, Cerebral Oedema, Accident Illuminating Gas Poisoning

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

3/12, 1930 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 13 1930
20 UNDERTAKER	ADDRESS
Jans Grbliauskas	4233 Pacific St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 54992

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54992

159-003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 6-10 Monument St. WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Martin Resnick

(a) RESIDENCE NO. 2118 Oram St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 5, 1930

7 AGE — Years: 0 — Months: 0 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: /

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Abraham Resnick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Anna Dubrinsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Hospital Records

15 Filed MAR 13 1930 — C. HAMPSON GIBBONS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-12- 1930

17

I HEREBY CERTIFY, That I attended deceased from 3-5, 1930, to 3-12, 1930,

that I last saw him alive on 3-12, 1930,

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital hypertrophic pyloric stenosis

(duration) ..... yrs. ..... mos. 3 wks ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ..... home.

Did an operation precede death? Yes Date of 3/11/30

Was there an autopsy? Pyloric Lumen

What test confirmed diagnosis? X Ray. Stom

(Signed) ..... M. D.

3/14, 1930 (Address) 2 min Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen Circle Cem

DATE OF BURIAL: 3/13 1930

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54993 E 54993

CERTIFICATE OF DEATH.

REGISTERED NO. 74091

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 7-13 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hobert Kobeck

(a) RESIDENCE NO. 1820 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED Butcher

(a) Trade, profession or particular kind of work ~~Unknown~~ 013

(b) General nature of industry, business, or establishment in which employed (or employer) J. A. Gebelein

(c) Name of employer Madison & Castle Sts.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed MAR 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-30

17 I HEREBY CERTIFY, That I attended deceased from 3-10-30, 19..., to 3-12-30, 19...

that I last saw h in alive on 3-12-30, 19...

and that death occurred, on the date stated above, at 1:45 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, 2d.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Hypertension over 4

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

3-12, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL March 14, 1930

UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NATIVITY should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-30—M. & T.—250 Blks.

E 54994

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 54994

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2601 Eastern Ave ST. 1-3 WARD)

2-FULL NAME Gustave Tribull Sr

(a) RESIDENCE NO. 2601 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Tribull

6 DATE OF BIRTH (month, day, and year) Oct 6th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Crockery ware

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Franz Tribull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Deibl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Tribull

(Address) 2601 Eastern Ave

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/1930

17 I HEREBY CERTIFY, That I attended deceased from March 1 , 1930, to March 10, 1930, that I last saw h[illegible] alive on March 10, 1930, and that death occurred, on the date stated above, at 2:45 P.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Myocarditis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo C Klemm D, M. D.

, 19 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Mar 13 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 54995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 54995

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 840 Tyson St. 11-24 Ward)

2-FULL NAME Ella Brooks

(a) RESIDENCE NO. 840 Tyson St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): May 7-1929

7 AGE: Years ..... Months 10 Days 2 If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Non
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Clarence Spicer

11 BIRTHPLACE OF FATHER (city or town): Balto.
(State or country): Md

12 MAIDEN NAME OF MOTHER: Lucy Brooks

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country): Md

14 Informant: Lucy Brooks
(Address): 840 Tyson

15 Filed ....., 19.... .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. C. Berman, M. D.

19 ..... (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 3-13 1930

20 UNDERTAKER: Daniel Easton — ADDRESS: 916 Pa

Spec.—2-29-28—L. F. S.—500 Bks.

E 54996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8 2 ✓ E 54996

REGISTERED NO. 54996

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 W 38 St. 12-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W Frank

(a) RESIDENCE NO. 1022 W 38 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Wid

5a If married, widowed or divorced HUSBAND of (or) WIFE Ida A Frank

6 DATE OF BIRTH (month, day, and year) July 6 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles W Frank

(Address) 1022 W 38 St

15 Filed 19 C. HAMPTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 30

17 I HEREBY CERTIFY, That I attended deceased from —, 19 26, to March 12 19 30

that I last saw him alive on March 12, 19 30

and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Multiple Neuritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? By exclusion

(Signed) Fred Stoll Jr., M. D.

3/13 1930 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Corrected 3-15 30

DATE OF BURIAL 19 30

20 UNDERTAKER Chenoweth & Son

ADDRESS 3417 Chestnut

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

54997 X 117 ✓ E 54997

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

12-51

1-PLACE OF DEATH

City of Baltimore: (No. U.S. Marine Hospital St. 12 Ward)

2-FULL NAME Charlie Rick

(a) RESIDENCE NO. 7910 Fifth Ave, Brooklyn N.Y. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 da. How long in U. S., if of foreign birth? 6 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 28, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	34	1	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) Seaman
(c) Name of employer S.S. J. C. White

9 BIRTHPLACE (city or town)
(State or country) Denmark

PARENTS

10 NAME OF FATHER Charlie Rick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Denmark

12 MAIDEN NAME OF MOTHER Anna Jensen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Denmark

14 Informant Hospital Records
(Address) U.S. Marine Hospital, Balto.

Filed MAR 13 1930 HAROLD JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes U.S. Marine Hospital

What test confirmed diagnosis?

(Signed) J. C. Wiseman, M. D.

3/12, 1930 (Address) 2632 Rutland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery	Mar 13 1930
20 UNDERTAKER E. LeRoy Stiffler, Inc	ADDRESS 125 E. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-8-25—A Co.—200 Bks.

E 54998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ E 54998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 Mc Henry St. Ward 13)

2-FULL NAME Beverly Stanton

(a) RESIDENCE NO. 920 Mc Henry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 5 1912

7 AGE — Years: 17 Months: 9 Days: 4 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Stanton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Cecelia Logan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Edna Stanton

(Address) 920 Mc Henry St.

15 Filed MAR 13 1930 19 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 8/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Insufficiency

(Fright-afriend entered his room thrd window late at night)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Owen, M. D. (Coroner)

3/12/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — Date of Burial: Mar. 14, 1930

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 125 Glenda

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 54999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 31 ✓

E 54999

1—PLACE OF DEATH U.S. marine Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Remington ave. & Wyman ST. Baltimore WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jose Brito

(a) RESIDENCE NO. 912 Hillman ST., WARD Hackensack N.J.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Brito

6 DATE OF BIRTH (month, day, and year) Sept 1 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work seaman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Transportation

(c) Name of employer Chatham

9 BIRTHPLACE (city or town) (State or country) Cape Verde Island Portugal

PARENTS

10 NAME OF FATHER John Brito

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cape Verde Island

12 MAIDEN NAME OF MOTHER Mary Silva

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cape Verde Island

14 Informant Hospital records (Address)

15 Filed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9 1930

17

I HEREBY CERTIFY, That I attended deceased from August 31, 1929, to March 9, 1930, that I last saw him alive on March 9, 1930 and that death occurred, on the date stated above, at 9 15 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary Chronic

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) John W. Trask, M. D.

19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery DATE OF BURIAL March 11 1930

20 UNDERTAKER ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55000 124 E 55000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen'l Hosp (WARD) 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Isenroad

(a) RESIDENCE NO. 903 N Potomac St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie E. Isenroad

6 DATE OF BIRTH (month, day, and year) July 22, 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)

PARENTS

10 NAME OF FATHER John Isenroad

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Henrietta Killian

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Marie E. Isenroad

(Address) 903 N. Potomac St. City

15 MAR 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/3, 1930, to 3/12, 1930, that I last saw h[illegible] alive on 3/12, 1930 and that death occurred, on the date stated above, at 4 P m

The CAUSE OF DEATH* was as follows:

~~Coronary~~ Chronic Myocarditis ?

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 45 minutes ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No (Date of)

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. A. Alesse M. D.

(Address) West Balto Gen'l Hosp, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery DATE OF BURIAL Mar 15, 1930

20 UNDERTAKER Wm. E. Miller & Son ADDRESS 2334 Eastern Ave.

MAR 13 1930

NOTE B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEPARTMENT OF HEALTH ... BALTIMORE

100-0E 55001

E 55001

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 7-10 Ward)

2-FULL NAME James M Briggs

(a) RESIDENCE NO. 504 N Post St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of The Late Elizabeth Briggs

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
79 78				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Balto.

PARENTS

10 NAME OF FATHER Briggs

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Not Known

14 Informant Ida Schubert
(Address) 504 N. Patterson Park Ave

15 Filed ....., 19..... C. THOMPSON JONES, M. D. Registrar

MAR 13 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho

..... (duration) ..... yrs. ..... mos. 2 wks. ds.

CONTRIBUTORY (Secondary) Dr Lawston

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? — What tests confirmed diagnosis? —

(Signed) C. A. Wade, M. D.

, 19 (Address) 432 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Mar 13 19
20 UNDERTAKER Wm C. Miller & Son	ADDRESS 433 N

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55002

CERTIFICATE OF DEATH

167-001

E 55002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 932 S. Kenwood Ave. St. 1-3 Ward)

2-FULL NAME JOSEPH E. FERGUSON

(a) RESIDENCE NO. 932 S. Kenwood Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) December 10, 1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O'H
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph E. Ferguson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mathilda Ernest

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs. Lillian Creamer (Sister)
(Address) 932 S. Kenwood Ave.

Filed MAR 13 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide-
Gas Poisoning Ill.
(duration) 6 hrs. mos. da.

CONTRIBUTORY (Secondary) Asphyxia
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? History-

(Signed) [illegible] M. D.
19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery

DATE OF BURIAL: Mar. 19 30

UNDERTAKER: Henry Sander & Sons. Inc.

ADDRESS: Baltimore St & Broadway

Spec.—1-30—M. & T.—250 Blks.

E 55003

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55003 ✓

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (Tbc.) 3-4

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Willis

(a) RESIDENCE NO. 1505 E. Lombard st. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Willis

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Edward Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Minnie Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records
(Address)

15 Filed MAR 13 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to March 10, 1930, that I last saw him alive on March 10, 1930, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumococcic pneumonia

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Jesse Gibson Jr. M. D.

3-11, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Georgia

DATE OF BURIAL March 12 1930

20 UNDERTAKER John W Henderson

ADDRESS 1502 E. Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 55004

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55004

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2550 Mc.Henry ST. 21-69 WARD)

2-FULL NAME Charles W. Leydecker.

(a) RESIDENCE NO. 2550 Mc. Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie A. Leydecker.

6 DATE OF BIRTH (month, day, and year) June 15th. 1863

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	8	23 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lamb Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) In Lexington Mkt

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Phillip Leydecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Julia A. Kempp.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) Mrs. Katie A. Leydecker. 2550 Mc. Henry St.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

Per RMC.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10th 1930 1930.

17 I HEREBY CERTIFY, That I attended deceased from February 23 1930 to March 10 1930,

that I last saw him alive on March 10 1930,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Thrombosis of Coronary

Aorta.

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert C. Nyhus, M. D.

3/12/30 (Address) 257 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery.

DATE OF BURIAL: Mar. 13, 1930

UNDERTAKER: George L. Schwab

ADDRESS: 2301 Eutaw Ave

MAR 13 1930

INSTRUCTIONS: PRINT PLAINLY, WITH UNFADING INK. THIS CERTIFICATE IS REQUIRED BY LAW. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

C 55005

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 55005

CERTIFICATE OF DEATH

REGISTERED NO. 22-31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 W. Hill — ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Melvin N. Harris

(a) RESIDENCE NO. 19 W Hill — ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Infant

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug-23-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	—	7	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Waverly Harris

11 BIRTHPLACE OF FATHER (city or town) Petersburg

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Rebecca Stewart

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Waverly Harris

(Address) 19 W Hill St

15 Filed MAR 13 1930 19 HAMILTON JONES, M. Registrar

PET

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/11/30

17 I HEREBY CERTIFY, That I attended deceased from 2/7, 1930, to 3/11, 1930,

that I last saw him alive on 3/11, 1930

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) David Franklin M. D.

3/11, 1930 (Address) 1220 N Dec St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	Mch 13 1930
20 UNDERTAKER John H Tradin	ADDRESS 1027 Druid Hill

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—3-29-24—1 M. F. S.—500 Blks.

E 55006

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55006

90

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2501 N. Calvert ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Sadtler

(a) RESIDENCE NO. 2501 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Maud A. Sadtler

6 DATE OF BIRTH (month, day, and year) March 11 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder Retired

(b) General nature of industry, business, or establishment in which employed (or employer) 076

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William J. Sadtler

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Heidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Henry C Shepherd

(Address) 2519 N Calvert St

15 Filed MAR 13 1930 C. HAMPSON GRIMES Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12. 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 5 1929, to March 12 1930, that I last saw h[illegible] alive on March 11 1930 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

(Senile changes) Arteria Sclerosis, chronic myocarditis about

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical & gen.

(Signed) J. Brand Brewer, M. D.

3/12, 1930 (Address) 2125 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL March 14, 1930

20 UNDERTAKER Chas. G. Black

ADDRESS 742 W North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 55907

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1347 Woodyear St. 15-23 Ward)

2-FULL NAME Ernestine Ford

(a) RESIDENCE NO. 1347 Woodyear St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) April 14 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
		10	23 25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) .....

PARENTS

10 NAME OF FATHER Ernest L Ford

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) .....

12 MAIDEN NAME OF MOTHER Ethel Brown

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) .....

14 Informant Ethel Ford
(Address) 1347 Woodyear

15 Filed ..... 19 ..... 1112 Mch 16 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 9th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas. L. Cornish M. D.
(Address) 1347 Woodyear

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL 19

20 UNDERTAKER .....

ADDRESS .....

MAR 13 1930

Per. Wm. E. Woodall

PLEASE PRINT PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

41

UNIVERSITY OF MARYLAND
THE MORGUE

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55008

CERTIFICATE OF DEATH.

100-001 ✓

E 55008

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 685 Josephine St. 4th Ward)

2-FULL NAME Gretta May Jones

(a) RESIDENCE NO. 685 Josephine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed 4 4 1930 RFH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Primary Broncho-pneumonia
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Eugene Feller M. D.
(Coroner)

3/11, 1930 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND. Date of Burial 19

20 UNDERTAKER ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

73

Cor.—10-10-29—A Co.—100 Bks.

E 55009

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55009

CERTIFICATE OF DEATH

31

1-PLACE OF DEATH

City of Baltimore: (No. 56 / Moore St. 17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Turner

(a) RESIDENCE NO. 56 / Moore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of no

6 DATE OF BIRTH (month, day, and year) March 5-1907

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	22	11	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work maid.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Butte Mont.
(State or country)

PARENTS

10 NAME OF FATHER Thos. Wynn

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Morris

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mary Risby
(Address) 928 Madison Ave

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(duration) ....yrs. ....mos. 12 da.

CONTRIBUTORY (Secondary)
(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Hoffman, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL: MAR 1 8 1930

20 UNDERTAKER G. HAMILTON JONES, M. D. — ADDRESS

R 17 1930 [illegible] THE MORGUE

R—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55010

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 32

E 55010

1—PLACE OF DEATH Mercy Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ST 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jerome Johnson Cedonville md

(a) RESIDENCE NO. 106 Mellon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	1	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hanover Penna
(State or country)

PARENTS

10 NAME OF FATHER Jerome F

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna

12 MAIDEN NAME OF MOTHER Oneida Snyder

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna.

14 Informant Hosp. Records.
(Address)

15 Filed ..... 19 ..... Registrar

MAR 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-5, 1930, to 3-13, 1930, that I last saw h[illegible] alive on 3-13, 1930 and that death occurred, on the date stated above, at 10 10 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Lepke, M. D.

3/13, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Joseph [illegible] Penna

DATE OF BURIAL Mar 14 1930

20 UNDERTAKER W. G. Fraser

ADDRESS Hanover Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓ E 55011

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. Mrs. Margaret Lane ST. H-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Lane Sharon Point

(a) RESIDENCE NO. 232 D. St ST., WARD Parrons Point

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Lane

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Alex Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Oconnor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Barth Lane

(Address) 108 S. Boulden St.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/10/30

17 I HEREBY CERTIFY, That I attended deceased from 3/5/30, 19..., to 3/10/30, 19..., that I last saw h[illegible] alive on 3/10/30, 19..., and that death occurred, on the date stated above, at 9.15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) David Inman, M. D.

3/10/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn — DATE OF BURIAL March 14, 19 30

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAU... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 55012

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55012

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1342 N. Bond St. (Ward) 8-17

2-FULL NAME Thomas H Rees

(a) RESIDENCE. No. 1342 N. Bond. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice H Rees

6 DATE OF BIRTH (month, day, and year) Dec 14-1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Park Police

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Fort Monroe Va

9 BIRTHPLACE (city or town) (State or country) Rochester N. Y.

PARENTS

10 NAME OF FATHER James Carlton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Youngstown O.

14 Informant Alice H Rees (Address) 1342 N Bond St

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MAR 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 9 1930 to Mar 12 1930

that I last saw him alive on Mar 12 1930

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hattie E. Buckman M. D.

3/13 1930 (Address) 2002 N. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Va

DATE OF BURIAL 3/15 1930

20 UNDERTAKER Robt J Turner

ADDRESS 1462 Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55013

CERTIFICATE OF DEATH.

101-001 55013

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2675 Hilleus St. (WARD) 20-72

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Saml H Hutchins

(a) RESIDENCE. NO. 2670 Hilleus ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgia A Hutchins

6 DATE OF BIRTH (month, day, and year) Feb-26-1860.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer & Sta

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer Bonne Timber Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robt Hutchins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nichols

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Georgia A Hutchins

Address 2675 Hilleus ass

15 Filed MAR 13 1930 C. HAMPSON JONES, M. D., Registrar

RFA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar-11 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar-2, 1930 to Mar-11, 1930

that I last saw h alive on Mar 11- 1930

and that death occurred, on the date stated above, at 1030 P m.

The CAUSE OF DEATH was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harley Cole, M. D.

3/12, 1930 (Address) 2202 Kenwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Mar 14 1930

20 UNDERTAKER: J Marvin Routson

ADDRESS: 223 W North

MAR 13 1930

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55914 ✓ E 55914

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Valley St. St. 10-14 WARD)

2-FULL NAME Humphreys Friel

(a) RESIDENCE NO. Little Sisters of the Poor WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Friel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Daugherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Good Mother

(Address) 1200 Valley St.

15 Filed MAR 13 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Mar 13, 1930, that I last saw h alive on Mar 13, 1930, and that death occurred, on the date stated above, at 2-5 P.M.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Genevieve M. D.

3/13/30 (Address) 1216 W Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Mar. 14 1930

20 UNDERTAKER Rita Friedfeld

ADDRESS 914 Fremont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU TION is very important. See instructions on back of certificate.

AR 1

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55015

CERTIFICATE OF DEATH.

100 1 V

E 55015

REGISTERED NO. 12-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. (WARD)

2-FULL NAME Mrs Julia Birkenwald

(a) RESIDENCE NO. 2303 Brookfield ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Marion Birkenwald

6 DATE OF BIRTH (month, day, and year): Dec 2, 1866

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
64	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER: Leman Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Stella Burbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. S. Birkenwald

(Address) 2303 Brookfield Ave

15 Filed MAR 13 1930 G. HAMPSON JONES, M. D., Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-1930

17 I HEREBY CERTIFY, That I attended deceased from 1/28, 1930, to 3-12, 1930.

that I last saw her alive on 3-12, 1930,

and that death occurred, on the date stated above, at 12 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy + Dilatation

Hypertension

Coronary Thrombosis.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) A. D. Silver, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 3/14/1930

20 UNDERTAKER: David Sondheim

ADDRESS 118-20 W. Mt. Royal Ave

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-001 ✓ E 55016

E 55016

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1916 Oak Hill ave ST., (WARD) 9-18

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothy V Fassel

(a) RESIDENCE NO. 1916 Oak Hill ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21st 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John K Fassel

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Alice V. Shaw

13 BIRTHPLACE OF MOTHER (city or town) Deweide Grace Md
(State or country)

14 Informant John K Fassel
(Address) 1916 Oak Hill ave

15 Filed ....., 19 .... Registrar

3 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 8, 1930, to Mch 13, 1930, that I last saw her alive on Mch 13, 1930 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

a Contusion of Cerebella & Diphtheria resulting in acute cardiac failure

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Hyde, M. D.

3/13, 1930 (Address) 1610 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 3/14 1930

20 UNDERTAKER George Schellinger Son

ADDRESS 1226 E Monument St

INFORMATION called for by this certificate is necessary for the protection of life and property, AND should be carefully supplied. AND should be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55017

38 ✓ E 55017

CERTIFICATE OF DEATH

REGISTERED NO. 8-44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4218 Harwood Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theodore L Miele

(a) RESIDENCE NO. 4218 Harwood Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	57	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Antique Iron

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis L Miele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Meyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant William A Miele

(Address) 4218 Harwood Ave

15 Filed ....., 19.... Registrar

MAR 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar-13-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930, to March 13, 1930

that I last saw h.. alive on March 12 1930

and that death occurred, on the date stated above, at 12 M. p.m.

The CAUSE OF DEATH* was as follows:

Aortic Aneurysm

(duration) ..... yrs. 14 mos. 14 ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) 0 yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & laboratory

(Signed) A. L. Gordy, M. D.

3-13-1930 (Address) 4218 Harwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	March 15 1930
20 UNDERTAKER	ADDRESS
Chas E. Miller	2435 E Alicia

MARRIED WOMEN should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55018

CERTIFICATE OF DEATH

27

E 55018

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 38 E 26th.St ST. 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha D. Cordell

(a) RESIDENCE NO. 38 E 26th.St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred LIFE mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene F. Cordell Jr.

6 DATE OF BIRTH (month, day, and year) Feb.25th.1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	52	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 027

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Eugene F. Cordell Jr

(Address) 38 E 26ths St

15 Filed MAR 14 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13-30

17 I HEREBY CERTIFY, That I attended deceased from March 1 1930, to March 13 1930

that I last saw her alive on March 12, 1930

and that death occurred, on the date stated above, at 11.2 a m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coma - Diabetes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hattie W Mintz M. D.

3/13 1930 (Address) 2800 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charlestown W Va.

DATE OF BURIAL: 3/14/30

20 UNDERTAKER: Harry A. Wetzke

ADDRESS: 411 Edmondson Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

OCT 6 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55019

CERTIFICATE OF DEATH

E 55019

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Md Gen Hosp St. 11-24 (Ward)

2-FULL NAME Herbert Earle Allen

(a) RESIDENCE NO. Joppa Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 - 1913

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	17	4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Detroit Mich
(State or country)

PARENTS

10 NAME OF FATHER Herbert D Allen

11 BIRTHPLACE OF FATHER (city or town) Ontario Canada
(State or country)

12 MAIDEN NAME OF MOTHER Thelma Judell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. Dakota

14 Informant Herbert D Allen
(Address) Joppa, Md.

MAR 13 1930, 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

Struck & Run down by by auto while walking along road on way to School

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(Duration) yrs. mos. ds.

Traumatic Shock

18 Where was disease contracted if not at place of death? Phila Rd & Joppa

Did an operation precede death? Yes Date of 3/11/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Braun, M. D.

3/13 1930 (Address) 2934 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon M.E. Cemetery	March 15 1930
20 UNDERTAKER	ADDRESS
Howard K McComas	Abingdon Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

Pearce
2107 N. Charles

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55020

CERTIFICATE OF DEATH.

E 55020

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2814 East Gibbons ST. (or AVE.) 91 00 37 44

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Regnier

(a) RESIDENCE NO. 2814 East Gibbons St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: Charles Regnier

6 DATE OF BIRTH (month, day, and year): Oct 23. 1853

7 AGE — Years: 76 — Months: 4 — Days: 19 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland U.S.A. Germany

PARENTS

10 NAME OF FATHER: George Ehrman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine Kreig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Regnier
(Address) 2814 East Gibbons

15 Filed APR 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 12/1930

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1929, to Mar 12, 1930

that I last saw h alive on Mar 12, 1930

and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Convulsion & Coma

(Signed) Wm. T. Pearce, M. D.

Mar 13, 1930 (Address) 2105 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emanuel Cemetery

DATE OF BURIAL: 3/15 1930

20 UNDERTAKER: William Cook

ADDRESS: 1217 St Paul Street

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55021 HEALTH DEPARTMENT—CITY OF BALTIMORE No. 55021

CERTIFICATE OF DEATH. 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 16-67 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas H. Carroll

(a) RESIDENCE NO. 3207 Gwynn Falls Parkway WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 22 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Portland (State or country) Maine

PARENTS

10 NAME OF FATHER Henry Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Hospital Records (Address)

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

APR 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-30

17 I HEREBY CERTIFY, That I attended deceased from 10-30, 1929, to 3-12, 1930, that I last saw him alive on 3-12, 1930, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Cystitis, chronic - hydronephrosis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Lobar pneumonia - right (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Ellis Kemp Jelly, M. D.

3-13, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery — DATE OF BURIAL 3/14/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 55022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55022

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2106 Chelsea Rd St. 5-66 WARD

2-FULL NAME Mary E Portier

(a) RESIDENCE. No. 2106 Chelsea Rd St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single, Married~~ Widowed, or ~~Divorced~~ (write the word) widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Louis Ed. Portier

6 DATE OF BIRTH (month, day, and year) April 21 1862

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER Wm McWilliams

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Dawson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Son- Ed Portier

(Address) 2106 Chelsea Terrace

15 Filed MAR 13 1930, 19 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13- 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930, to March 13, 1930, that I last saw her alive on March 12, 1930, and that death occurred, on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

10-15 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Cerebral (duration) several yrs. mos. ds.

18 Where was disease contracted if not at place of death? aged.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) Walter Richards, M. D.

, 19 (Address) 922 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL 3/15/ 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

MAR 13 1930

INFORMATION.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 55023

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55023

CERTIFICATE OF DEATH.

129

REGISTERED NO. 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2605 Strathmore ST. WARD

2-FULL NAME Thomas Henderson Davis

(a) RESIDENCE NO. 2605 Strathmore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ollah See Davis

6 DATE OF BIRTH (month, day, and year) Sept 24-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Pipe fitter

(b) General nature of Industry, business, or establishment in which employed (or employer) 060

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va.

PARENTS

10 NAME OF FATHER James Early Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER Sarah Jane Owsley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Country

14 Informant Ollah L. Davis

(Address) 2605 Strathmore Ave

15 Filed MAR 13 1930, 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1930

17 I HEREBY CERTIFY, That I attended deceased from July- 1926 to March 12 1930

that I last saw him alive on March 12 1930

and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) H C Hess, M. D.

3/12 1930 Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon pk

DATE OF BURIAL 3/14 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 55024

HEALTH DEPARTMENT—CITY OF BALTIMORE

Baltimore

E 55024

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (St.) 9-46 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Barnaba

(a) RESIDENCE No. 1746 East 25th St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Barnaba

6 DATE OF BIRTH (month, day, and year): 8 | 25 | 1894

7 AGE: Years 35 Months 6 Days 16 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor oil

(b) General nature of industry, business, or establishment in which employed (or employer): Buckeye

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Salvatore Barnaba

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rose Munnie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: C. Tucchesi

(Address) 1246-E. 25th St

15 Filed MAR 14 1930 H. [illegible] JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-11 19 30

17 I HEREBY CERTIFY, That I attended deceased from 3-5- 19 30 to 3-11 19 30

that I last saw h[illegible] alive on 3-11 19 30

and that death occurred, on the date stated above, at 2.P. m.

The CAUSE OF DEATH* was as follows:

Uraemia - (Chronic Nephritis)

(Duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pneumonia (Terminal

(Duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 3/14/30

20 UNDERTAKER: George J. Muth

ADDRESS: 1725 Harford

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 55025

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hospital St. 15-54 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Wilhelmina Engelbach

(Residence in Baltimore: No. 2532 Pennsylvania av St.; 68 yrs., 4 mos. 12 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Oct 31 (Month) (Day) 1861 (Year)

7-AGE: 68 yrs. 4 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: H W. 037
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: Henry Hagendorn

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Englebach

(Address) 2532 Pennsylvania Av

MAR 14 1930

H. HANSON JONES, M. D.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Mar (Month) 12 (Day) 1930 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar caught
Fire from Gas Stove at
Home

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. ....mos. ....ds.

(Signed) C. Lee Hall Smith, M. D.
(Coroner)

3/13 1930 (Address) 1401 33

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loraine Cem DATE OF BURIAL MAR 15 1930

20-UNDERTAKER, Geo W Little ADDRESS 2700 EDMONDSON AVE.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

234170 E 55026 CERTIFICATE OF DEATH X 135 ✓ E 55026

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elitah Triplett

(a) RESIDENCE NO. Elkins, W. Va ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Triplett

6 DATE OF BIRTH (month, day, and year) Jan 18 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER Jacob Triplett

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Hulda Kittle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb-18, 1930, to March 13, 1930, that I last saw h[illegible] alive on March 13, 1930 and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature], M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkins W. Va — DATE OF BURIAL March 14 1930

20 UNDERTAKER Geo W Little — ADDRESS 270 Edmondson Ave

Before writing, read carefully the instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 17 1930 H. JAMESON JONES, M.D.

Spec.—1-30—M. & T.—250 Blks

E 55027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 E 55027

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 E. Lanvale St. 17-19 WARD)

2-FULL NAME Frederick Rauch

(a) RESIDENCE NO. 435 E. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Annie Rauch

6 DATE OF BIRTH (month, day, and year) 12/15/1857

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Rauch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Rauch (Address) 435 E Lanvale St

15 Filed MAR 14 1930 C. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/30

17

I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to March 13, 1930, that I last saw h— alive on March 13, 1930, and that death occurred, on the date stated above, at 1-45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm Pearce, M. D.

3-13-1930 (Address) 17 Paul & Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 3/17/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55028

100-001

E 55028

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1511 Jefferson ST., 6-9 WARD)

2—FULL NAME Elmer Atwill Pattillo

(a) RESIDENCE NO. 1511 Jefferson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 14, 1928

7 AGE — Years: 1 2 — Months: 11 — Days: 16 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Atwill Pattillo

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sallie Smith

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Sallie Pattillo
(Address) 1511 Jefferson st.

15 Filed MAR 14 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 10. 30

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1930, to Mar 10, 1930

that I last saw h alive on Mar 10, 1930

and that death occurred, on the date stated above, at 6:05 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) Wm. C. Roy Berry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary

DATE OF BURIAL: Mar 14 1930

20 UNDERTAKER: Mrs. R. A. Elliott

ADDRESS: 1725 Gaskland

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55029

CERTIFICATE OF DEATH

101-001 E 55029

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 931 Lauretta St., 20-27 Ward)

2-FULL NAME Wm H. Middleton

(a) RESIDENCE NO. 931 Lauretta St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): Feb 25 - 1930

7 AGE: Years | Months | Days 13 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER: Edwin Middleton

11 BIRTHPLACE OF FATHER (city or town): Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER: Ethel Lindsay

13 BIRTHPLACE OF MOTHER (city or town): Baltimore Md
(State or country)

14 Informant: Ethel Middleton
(Address): 931 Lauretta St

15 Filed ....., 19.... Registrar

MAR 14 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Lobar Pneumonia

(duration) ....yrs. ....mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) J. T. Leach, M. D.

19 (Address) June 13 1930 Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: March 15 1930

20 UNDERTAKER: Joseph A. Lively — ADDRESS: 4092 Mount St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55030

VE 55030

154-00

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 N. Castle ST., 6-9 WARD)

2-FULL NAME Bertha Marie Bach

(a) RESIDENCE NO. 211 N. Castle ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 4th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		7 6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John A. Bach

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Rosenberger

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant John A. Bach
(Address) 211 N. Castle St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 10/30

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 10, 1930, that I last saw her alive on March 10 1930 and that death occurred, on the date stated above, at 7.00 m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Trouble

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Ky Leach M. D.

Mch 13 1930 801 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Mch 14 1930

20 UNDERTAKER: Lilly & Zeller Inc — ADDRESS: 1018 W. Lafayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55031

CERTIFICATE OF DEATH

101-001

E 55031

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3106 Walbrook ave ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Read.

(a) RESIDENCE NO. 3106 Walbrook ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles R Read.

6 DATE OF BIRTH (month, day, and year) April 6-1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles A Crosly.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mitilda Free

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Charles R Read.

(Address) 3106 Walbrook ave.

Filed MAR 14 1930 SHANNON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-30

17 I HEREBY CERTIFY, That I attended deceased from 3-9-, 1930, to 3-12, 1930, that I last saw h[illegible] alive on 3-12, 1930 and that death occurred, on the date stated above, at 6.40 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Toxemia & Cardiac failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. O'Malley M. D.

3/13/30 (Address) 2757 La Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL March 15 1930

20 UNDERTAKER Billy Beiler INC

ADDRESS 403 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26 A Co. 200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55032

CERTIFICATE OF DEATH

74-001

E 55032

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave Ward 20-27)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Alice Brown

(a) RESIDENCE NO. Home for the Aged of the M. E. Church Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Aug 11 - 1850.

7 AGE	Years	Months	Days
	79	7	1

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Ira Brown.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Badger.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Etta Sunday

(Address) 400 N Fulton Ave

15 Filed MAR 14 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 - 1930.

17 I HEREBY CERTIFY, That I attended deceased from Febry 24, 1930, to March 12, 1930, that I last saw her alive on March 11, 1930, and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy -

(duration) ✓ yrs. ✓ mos. 15 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Geo. L. Shannon M. D.

3/13. 1930 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial Mar 14 1930

20 UNDERTAKER George J Smith — ADDRESS 53 L Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55033 ✓002 E 55033

CERTIFICATE OF DEATH

+ 7H

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hosp. ST., [illegible] WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. William Landis (Mary Francis)

(a) RESIDENCE NO. Oxford, N.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. 10 dys. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Mr. Wm Landis

6 DATE OF BIRTH (month, day, and year) May 6, 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Morstead
(State or country)

PARENTS

10 NAME OF FATHER W^m Francis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Sarah Cowan

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant William Landis
(Address) Oxford N Carolina

15 Filed MAR 14 1930, 19[illegible] [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1930, to March 14, 1930, that I last saw her alive on 4:30 A.M 3/14 1930 and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Cerebral embolus
Cholecystectomy 8 da. P.O.
[illegible]

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pernicious anemia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 6, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel McC Lunsford M. D.

Mch 14 1930 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Henderson North Carolina	March 14 1930
20 UNDERTAKER	ADDRESS 133 E
J Vernon Keehner	Baltimore

BOARD OF HEALTH

BEFORE signing or writing on this certificate, READ carefully the instructions on the back. Answer each question in full. Use figures for dates. Be sure that AGE, NAME OF DECEASED, CAUSE OF DEATH and DATE OF BURIAL are stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55034

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-901 E 55034

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp. ST. 15-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Connelly

(a) RESIDENCE NO. 1339 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	53	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore. Off

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant John Sunkett.

(Address) 1339 Woodyear St.

15 Filed 4 1930 C. HAMILTON JONES, M. D. Registrar

Keen

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10-30

17 I HEREBY CERTIFY, That I attended deceased from 3-6-30, 1930, to 3-10, 1930, that I last saw him alive on 3-10, 1930 and that death occurred, on the date stated above, at 9:45 p m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gangrene of left foot

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3-7-30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. C. Partenfield, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 14 1930
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1303 Preston St

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55035

CERTIFICATE OF DEATH.

E 55035

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 S. Hanover St) 23-31 (WARD)

2-FULL NAME Jacob Dittmar

(a) RESIDENCE NO. 1008 S. Hanover. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie M. Dittmar

6 DATE OF BIRTH (month, day, and year): April 29th 1866

7 AGE — Years: 63 Months: 10 Days: 13 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John G. Dittmar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Annie M. Dittmar 1008 Hanover St

15 Filed MAR 14 1930, 19 — JAMES H. HOOTS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March. 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1930, to March. 12, 1930, that I last saw h alive on March 12, 1930 and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 0 yrs 0 mos. 18 ds.

CONTRIBUTORY (Secondary): Acute myocarditis

(duration) 0 yrs 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Chas Uffenstadt, M. D.

, 19 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: March 16 1930

20 UNDERTAKER: C. Schlosman Son — ADDRESS: 1029 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Mks.

E 55036

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 55036

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 328 S. Monroe

CITY OF BALTIMORE: (No.) Balto ST., W 28 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virgie Lee Mangold

(a) RESIDENCE NO. 3288, Monroe ST., 19 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 6-1924

7 AGE: Years 5 Months 9 Days 8 1 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Charles Mangold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Lena E. Lehman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs. Lena E. Lehman

(Address) 328 S. Monroe St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.13 1930

17

I HEREBY CERTIFY, That I attended deceased from 3.12, 1930, to 3.13, 1930,

that I last saw h[illegible] alive on 3.12, 1930,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Bronchial Croup (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. D. Lightner, M. D.

3/13 1930 (Address) 211 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery DATE OF BURIAL Mar. 15 1930

20 UNDERTAKER George L. Schmidt ADDRESS 110 Chuck Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55037 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 55037

CERTIFICATE OF DEATH.

122-002

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) (St.) 70-69 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia R. Miller

(a) RESIDENCE No. 141 S. Calverton Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Miller

6 DATE OF BIRTH (month, day, and year) March 8, ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.,

(State or country) Md.

PARENTS

10 NAME OF FATHER John McCormick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia Gorsuch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed MAR 14 1930 H. LINCOLN JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13-30

17

I HEREBY CERTIFY, That I attended deceased from 2-13-30, 19, to 3-13-30, 19,

that I last saw her alive on 3-13-30, 19,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) over 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Marion M. McCleary M. D.

3-13 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 15 1930

20 UNDERTAKER George L. Schwab — ADDRESS 701 Cook Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 55038

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 705 Eislen St. 21-24 Ward)

2-FULL NAME Robert Gardner

(a) RESIDENCE NO. 705 Eislen St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Gardner

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm H. Gardner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs L. Stephens
(Address) Phila. Pa.

15 Filed ..... 19 ..... Registrar

4 1930 C. Hinkel Jr., M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feldy, M. D.

3/14. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 3/14 1930

20 UNDERTAKER Walter B. Jones

ADDRESS 2300 Hanlon St

IMPORTANT: PLEASE PRINT, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 55039 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55039

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3409 Bunker ST. 12-49 WARD

2-FULL NAME Jefferson Thompson

(a) RESIDENCE No. 3409 Bunker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Cecilia Thompson

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 74 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Flora Thompson 3409 Bunker

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar-11-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 — 1930 to Mar-11 1930

that I last saw h alive on Nov 10 1930

and that death occurred, on the date stated above, at 1:50 A m.

The CAUSE OF DEATH was as follows:

Bronchial pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) influenza

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Nothing

(Signed) W. J. Columbus M. D.

19 (Address) 2039 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 3/14 1930

20 UNDERTAKER: Samuel Heverley

ADDRESS: 1178 N Bridle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Johnson ✓

E 55940 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 55040

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 44-20 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Johnson

(a) RESIDENCE NO. 2231 Madison Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Essex Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Adam Grant

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Edith Holmes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed MAR 14 1930, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-30

17 I HEREBY CERTIFY, That I attended deceased from 3-6-30, 19..., to 3-12-30, 19...,

that I last saw her alive on 3-12-30, 19...,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic Interstitial over 5 Feet (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab.

(Signed) Marion M. McLean, M. D.

3-12, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem.

DATE OF BURIAL 3/15 1930

20 UNDERTAKER Samuel T. Hemsley for Biddle

ADDRESS 2728

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 55041

CERTIFICATE OF DEATH

E 55041

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5304 Sibley Ave ST., 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nicholas L. Leris.

(a) RESIDENCE NO. 5304 Sippel ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 3rd 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Anthony Leris

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Chimard

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Anthony Leris

(Address) 5304 Sippel Ave

15 Filed MAR 14 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 13- 1930

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to March 13, 1930

that I last saw him alive on March 13, 1930

and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Seven months Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. L. Valentine M. D.

(Address) 64 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cmtt.

DATE OF BURIAL March 19 1930

20 UNDERTAKER Lilly Zell Inc.

ADDRESS 403 S. Sharp St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55042

CERTIFICATE OF DEATH.

129

E 55042

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 929 N. Bond ST., 7-13 (WARD)

2-FULL NAME Elizabeth Monroe

(a) RESIDENCE NO. 929 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced (or) WIFE of Henry Monroe

6 DATE OF BIRTH (month, day, and year) 5-9-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1871		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Henry Monroe (Husband)

(Address) 929 N Bond St

15 Filed MAR 14 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1930, to Mar 13, 1930, that I last saw h alive on Mar 12, 1930, and that death occurred, on the date stated above, at 9 05 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine etc

(Signed) H. P. Stugler, M. D.

3/13, 1930 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Samuel Cemetery	Mar 16 1930
UNDERTAKER	ADDRESS
Robert C. Williams	1515 McElderry St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 55043 HEALTH DEPARTMENT—CITY OF BALTIMORE

58-002 E 55043

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital Eastern Ave & Caroline St

CITY OF BALTIMORE: (No. Baltimore Md ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Angela Majchrzak

(a) RESIDENCE NO. 102 S. Ellwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John. Majchrzak.

6 DATE OF BIRTH (month, day, and year) April 29-1900

7 AGE: Years 29 Months 10 Days 13 If LESS than 1 day, ...hrs. or min. 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Stanislaus Wlodarek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Rozalia Krupska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant (Address) Mr. Stanislaus Wlodarek 412 S Wolfe street

15 Filed MAR 14 1930 19 C. HARRISON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1930

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to March 13th 1930 that I last saw her alive on March 13, 1930, and that death occurred, on the date stated above, at 4.15 A.m.

The CAUSE OF DEATH* was as follows:

Bantis Disease

1 st known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 3/7/30

Was there an autopsy? no Pathology

What test confirmed diagnosis? Clinical

(Signed) M. Ludany, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart of Mary

DATE OF BURIAL: March 15 1930

UNDERTAKER: George A. Weber

ADDRESS: 705 S. Ann St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55044

CERTIFICATE OF DEATH

161-001
E 55044

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1840 McCulloh St. (WARD) 14-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Banks

(a) RESIDENCE NO. 1840 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 3/11/30

7 AGE — Years | Months | Days: 1 day | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Gene Whitlock

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ada Norris Banks

13 BIRTHPLACE OF MOTHER (city or town) Aberdeen
(State or country) Md

14 Informant Ada Norris Banks
(Address) 1840 McCulloh St.

15 Filed 19 C. HAMILTON JONES, M. D.
Registrar

MAR 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/12/30

17 I HEREBY CERTIFY, That I attended deceased from 3/11, 19 30, to 3/12, 19 30,

that I last saw him alive on 3/12, 19 30

and that death occurred, on the date stated above, at 10:55 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Stopping of Heart Beat.

(Signed) M. Alexander Novey, M. D.

3/13, 1930 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS MAR 13 1930

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55045 E 55045

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital. REGISTERED NO. 129

CITY OF BALTIMORE: (No. 26-41 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilhelmina Margaret Gunkel

(a) RESIDENCE NO. 3107 Berkshire Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Tel Phone Co

(c) Name of employer C & P Phone Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Gunkel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Roesner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp. Records

(Address)

15 Filed MAR 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-30

17 I HEREBY CERTIFY, That I attended deceased from 3-9, 1930, to 3-12, 1930, that I last saw her alive on 3-12, 1930 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Uterine fibroid

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/10/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + operation.

3/12/30 (Signed) J. Guyton, M. D.

(Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Mch 15, 1930
20 UNDERTAKER	ADDRESS
Hughes Jones Inc	1411 N Broadway

OR DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 55046

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 11-24 WARD)

2-FULL NAME Levinia Hill

(a) RESIDENCE NO. 322 Camel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Hill

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Garrison Slaughter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Allison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address) Wm James Hill 322 Camel St.

15 Filed 4-1-1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-30

17 I HEREBY CERTIFY, That I attended deceased from 2-19, 1930, to 3-12, 1930,

that I last saw her alive on 3-12, 1930,

and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) Unknown mos. da.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) L. C. Thompkins, M. D.

3-13 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery

DATE OF BURIAL 3-15-1930

20 UNDERTAKER Chas G. Cooper

ADDRESS 514 N. Calhoun St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 14 1930

Cor.—10-10-29—A Co.—100 Bks.

E 55047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

REGISTERED NO. 55047

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Josephs Hospital St., 8-17 Ward)

2-FULL NAME Lawrence B. Talbott

(a) RESIDENCE NO. 1718 Rutland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. da. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/23/1879

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
50	5	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Water Dept
(c) Name of employer Balto City

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Lawrence B. Talbot

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Cookery

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Washington D.C.

14 Informant Guy H. Talbott
(Address) 1718 Rutland Ave

15 Filed 19 C. CHAMPSON JONES M.D. Registrar

R 14 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/12/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured skull auto accident

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Fract Femur

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? Lay & Eden Sts

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. J. Fraser M. D.

3/14/1930 (Address) 2439 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery — DATE OF BURIAL 3/15/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55048

CERTIFICATE OF DEATH

129 E 55048

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 717 N. Montford Ave St., 7-12 Ward)

2-FULL NAME Josephine Pinkas

(a) RESIDENCE NO. 717 N. Montford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Pinkas

6 DATE OF BIRTH (month, day, and year) Jan 15/1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	1	25 27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework 037
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Bohemia

PARENTS

10 NAME OF FATHER John. Hanus

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Anna Stankonic

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia

14 Informant Joseph Pinkas (son)
(Address) 717 N Montford Ave

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Failure

Hypertension- Chr Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

3/13/30 (Address 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL May 15 1930

20 UNDERTAKER Frank Bracksieck — ADDRESS 1901 Oldford

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55049 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 55049

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 18-16 ST. (or WARD)

2-FULL NAME Clarence Jones

(a) RESIDENCE NO. 658 Fremont St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington

(State or country) D.C.

PARENTS

10 NAME OF FATHER Lucus Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed MAR 14 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-9-30

17 I HEREBY CERTIFY, That I attended deceased from 1-21-30, 19.., to 3-9-30, 19..,

that I last saw him alive on 3-9-30, 19..,

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage cerebrum, left

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Hypertension over

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

3-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

UNIVERSITY OF MARYLAND

C. HAMPSON JONES, M.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAR 14 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

Woods ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) 18-26 ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Woods

(a) RESIDENCE NO. 1006 Wagon Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Jan. 7, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chattanooga (State or country) Tenn.

PARENTS

10 NAME OF FATHER James Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Delia Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 4-1-30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10-30

17 I HEREBY CERTIFY, That I attended deceased from 2-13-30, 19..., to 3-10-30, 19...,

that I last saw h... in alive on 3-10-30, 19...,

and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis, chronic & acute

(duration) over 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic & acute: Hypertension (duration) over 1 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Theron T. McLean, M. D.

3-10, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAR 14 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-TION is very important. See instructions on back of certificates.

41030 4-453

Spec.—2-29-28—L. F. S.—500 Bks.

E 55051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 55051

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1675 Montpelier ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mathilda Steinmiller

(a) RESIDENCE NO. 1675 Montpelier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Steinmiller

6 DATE OF BIRTH (month, day, and year) Dec 27 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Kress

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Colbourn

13 BIRTHPLACE OF MOTHER (City or town) Ireland (State or country)

14 Informant Elizabeth Steinmiller daughter

(Address) 1675 Montpelier

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13-1930

17 I HEREBY CERTIFY, That I attended deceased from February 26, 1930, to March 13, 1930, that I last saw h.. alive on March 13, 1930 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Hypostatic (18 mo) Duration Months 2 yrs

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symp. + Urinalysis

(Signed) Thos J. A Stevens, M. D.

3/17, 1930 (Address) 2878 Halford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Angel Hill Cem Harwood Md

DATE OF BURIAL Mar 16, 30

20 UNDERTAKER W. Madison Mitchell

ADDRESS Harwood Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

14 1930

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55952 ✓ 46 E 55952

E 55952

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 616 E. 34th St., 9th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Louise (Nagle) Livezey

(a) RESIDENCE NO. _____ St. _____ Ward Aberdeen, Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. K. Livezey

6 DATE OF BIRTH (month, day, and year) April 20th 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	53	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bel Air

(State or country) Harford Co., Md.

PARENTS

10 NAME OF FATHER Thos. S. Nagle

11 BIRTHPLACE OF FATHER (city or town) Rocks

(State or country) Harford Co. Md.

12 MAIDEN NAME OF MOTHER Eliz. Hutcheson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scotland

14 Informant Geo. K. Livezey

(Address) Aberdeen, Md.

15 Filed APR 14 1930 19 C. HAMPSON JONES, M. D. Registrar

AR 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13 1930

17

I HEREBY CERTIFY, That I attended deceased from Dec 27, 1929, to Mar 13, 1930, that I last saw her alive on Mar 11, 1930, and that death occurred, on the date stated above, at 7.40 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 4 mos. ✓ ds.

CONTRIBUTORY (Secondary)

(durntion) yrs. mos. ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Pillsbury M. D.

. 19 (Address) 415 Cedar Croft Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baker Cemetery Harford Co.	March 16 1930
20 UNDERTAKER	ADDRESS
Henry Fanning Sons	Aberdeen Md

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAU... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55053

CERTIFICATE OF DEATH

112 E 55053

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St., 22-30 Ward)

2-FULL NAME Paul Crockett (C) or William Walker (C)

(a) RESIDENCE NO. 102 N. Hill St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, ~~widowed or divorced~~ HUSBAND of (or) ~~WIFE of~~ Elizabeth Crockett. (C)

6 DATE OF BIRTH (month, day, and year) August 1, 1890

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
✓	39	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer) Chesapeake S/S Co.
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina
(State or country)

PARENTS

10 NAME OF FATHER Isam Walker. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Malinda Rainey. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina

14 Informant Elizabeth Crockett. (C) wife.
(Address) 102 N. Hill St.

15 Filed ....., 19.... Registrar

APR 14 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastritis.

Oedema of the Lungs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & Inquiry

(Signed) Chas. M. Reinhardt, M. D.

3/12. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gastonia N. C.

DATE OF BURIAL 3-14-1930

20 UNDERTAKER John H. Trodvine

ADDRESS 021 Hund Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Hall ✓

E 55054

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55054

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 11-24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hall

(a) RESIDENCE NO. 1039 N. Eutaw Place ST., ... WARD .....

(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Hall

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Augusta (State or country) Ga.

PARENTS

10 NAME OF FATHER William Hall

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ga.

12 MAIDEN NAME OF MOTHER Jenny Crump

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-13-30

17 I HEREBY CERTIFY, That I attended deceased from 3-4-30, 19..., to 3-13-30, 19...,

that I last saw him alive on 3-13-30, 19...,

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Acute

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Nephritis, Chronic ?

Poliomyelitis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical: Autopsy

(Signed) Marion M McLean, M. D.

3/14, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL 3-17 1930

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Hanover

Spec.—1-12-23—M&T—500 Blks.

E 55055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE:, (No. 1310 Division ST., 17th WARD)

2-FULL NAME William Davis

(a) RESIDENCE NO. 1310 Division ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Davis

6 DATE OF BIRTH (month, day, and year) Feb 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Amelia Waldo

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Eloyza Davis
(Address) 1310 Division St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to March 13, 1930, that I last saw h... alive on March 13, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

Jan 2 to March 13
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis
(duration) 8 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Edw. J. Healey, M. D.
3, 1930 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 3-16-1930

20 UNDERTAKER John H. Broaden — ADDRESS 1027 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1 4 1930

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55056

CERTIFICATE OF DEATH.

E 55056

REGISTERED NO. 17

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 3-59 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carolyn Mayer Carolyn Mayer

(a) RESIDENCE NO. 2212 Linden Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1926

7 AGE: Years 3 Months 3 Days 20. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Adt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Jacob Mayer

(Address) 2212 Linden Ave

15 Filed , 19 Registrar

C. HAMPSON JONES, M. D.

R 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/10, 1930, to 3/12, 1930,

that I last saw h[illegible] alive on 3/12, 1930,

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis

(duration) yrs. mos 4 days

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Sinai

Did an operation precede death? Yes Date of 3/12/30

Was there an autopsy? Yes.

What test confirmed diagnosis? Abdominal tap; Operation

(Signed) Louis E. Clapp, M. D.

, 19 (Address) 1 Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Har. Sinai Cem.

DATE OF BURIAL 3/16/1930

20 UNDERTAKER David Sonnheim

ADDRESS 1820 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

237455 E 55057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 172-002 E 55057

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie Molesworth

(a) RESIDENCE NO. Reisterstown ST. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
~~HUSBAND~~ (or) WIFE of Louis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Bayly

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Hood

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar-17-30

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25 1930, to Mar-17, 1930, that I last saw her alive on Mar-17, 1930 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) ? 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Mar 4, 1930 Internal Circulation

Was there an autopsy? No

What test confirmed diagnosis? Opinion

(Signed) C. Hampson Jones, M. D.

March 14 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel Cemetery Reisterstown DATE OF BURIAL Mar 17 1930

20 UNDERTAKER J. F. Ellis ADDRESS Reisterstown Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Dr Hattle 1219 Hillsdale St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55058

E 55058

CERTIFICATE OF DEATH.

11-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 205 N. West St. (WARD) 23-31

2-FULL NAME William H. Becker Jr

(a) RESIDENCE NO. 205 N. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William H Becker Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Grace Haynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm H Becker Jr

(Address) 205 N West St

15 Filed 3/4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/26, 1930, to March 14, 1930, that I last saw him alive on March 14, 1930, and that death occurred, on the date stated above, at 5:40 A m.

The CAUSE OF DEATH* was as follows:

Bronchus Pneumonia (duration) yrs. mos 9 da.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? — Date of —

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C Mitchell, M. D.

3/14, 1930 (Address) 1219 Hillsdale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 3/15 1930

ADDRESS 1217 E Fayette St

20 UNDERTAKER Wm Cook

CAUSE OF DEATH must be stated plainly, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 55059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Marie Fitze

(a) RESIDENCE NO. 645 West Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Chas E Fitze

6 DATE OF BIRTH (month, day, and year) 11/31/76

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54 Yrs.	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER F. M. Gallager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Schell

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Chas N Fitze

(Address) 645 W. Lombard St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10th, 1930, to March 14th, 1930, that I last saw her alive on March 14th, 1930 and that death occurred, on the date stated above, at 7:15 A.m.

The CAUSE OF DEATH* was as follows:

Hypertensive Heart Disease with Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Haemorrhage

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Lewis P Lindsay, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL 3/17/1930

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks. Dr. Campbell 1644 Hanover St ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55060

CERTIFICATE OF DEATH

90 E 55060

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1439 Riverside Av (St.) 14-33 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas C. Mellenbury

(a) RESIDENCE NO. 1439 Riverside Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 9 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie Mellenbury

6 DATE OF BIRTH (month, day, and year): June 15 1849

7 AGE: Years 77 | Months 9 | Days 2 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: T. Mellenbury

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas E. Mellenbury
(Address) 1439 Riverside Av

15 Filed ....., 19 .....
APR 4 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/12/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to Mar 12, 1930,

that I last saw h... alive on Mar 12, 1930

and that death occurred, on the date stated above, at 1:20 a m.

The CAUSE OF DEATH* was as follows:

1 Uremia Nephritis

Influenza

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ....yrs. ....mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. C. Campbell M. D.

Mar 13, 1930 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	Mar 15 1930
20 UNDERTAKER	ADDRESS
H. S. Neufeld	1853 W. Lafayette Av

important. See instructions on back of certificates.

Spec.—8-16-19—L. F. S.—100 Bks.

E 55061

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 55061

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 N. Carolina St. 5-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James E. Smothers

(a) RESIDENCE NO. 216 N. Carolina ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Elizabeth Smothers

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Smothers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Elizabeth Smothers

(Address) 216 N Carolina

15 Filed MAR 15 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 14-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 7th, 1930, to Mar 14, 1930, that I last saw h. living on Mar 13, 1930 and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Acute Croupous Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Lucas Elder, M. D.

3-14 1930 (Address) 508 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Antioch Cemetery	Mar. 17 1930

20 UNDERTAKER Chas. H. Johnson ADDRESS 416 N. Carolina St.

IMPORTANT. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Pks.

E 55062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 55062

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 600 S. Rose St. 1-3 Ward)

2-FULL NAME Jozefa Kopczynska

(a) RESIDENCE NO. 660 S. Rose St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Wladyslaw

6 DATE OF BIRTH (month, day, and year): June 27, 1891

7 AGE: Years 38 | Months 9 8 | Days 16 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) _____ (State or country) Poland

PARENTS

10 NAME OF FATHER Jan Marciszak

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) Poland

12 MAIDEN NAME OF MOTHER Linik

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) Poland

14 Informant: Walter Kopczynski (Address) 660 S. Paul St.

15 Filed _____ 19__ C. HAMPSON JONES, M. D. Registrar

MAR 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1930, to March 12, 1930.

that I last saw her alive on March 12, 1930.

and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ____ yrs. ____ mos. 1 0 ds.

CONTRIBUTORY (Secondary) Acute Pericarditis

(duration) ____ yrs. ____ mos. 1 9 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? C. & S.

(Signed) John J. Kluge, M. D.

3/14, 1930 (Address) 627 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial: March 17 1930

20 UNDERTAKER: J. W. Bazewski ADDRESS: 1930 Eastern

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55963

100-001 E 55963

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1142 Battery Avenue ST. 24-13 WARD

2—FULL NAME Baby boy Burgess

(a) RESIDENCE NO. 1142 Battery Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Baby.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-9-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Burgess

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Marie Hassell

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Marie Burgess.
(Address) 1142 Battery Avenue.

15 Filed MAR 15 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14-30

17 I HEREBY CERTIFY, That I attended deceased from 3-9-30, 1930, to 3-14-30, 1930, that I last saw him alive on 3-13-30, 1930 and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia.

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) H. Alexander Hovey, M. D.

3/14, 1930 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill. DATE OF BURIAL Mar. 15 1930

20 UNDERTAKER William Cook ADDRESS 1217 St. Paul St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55064

101-001

E 55064

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2828 Montebello Ave ST., 9-46 WARD)

2—FULL NAME Albert Roby Martin

(a) RESIDENCE NO. 2828 Montebello Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18-1926

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	3	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Garland Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Va

12 MAIDEN NAME OF MOTHER Marie Doster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Martin
(Address) 2828 Montebello Ave.

15 Filed ___, 19 ___ Registrar

APR 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13-1930

17 I HEREBY CERTIFY, That I attended deceased from 3-10, 1930 to 3-13, 1930

that I last saw h alive on 3-13, 1930

and that death occurred, on the date stated above, at 1145 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) acute Endocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ___

Did an operation precede death? No Date of ___

Was there an autopsy? No

What test confirmed diagnosis? Gunning

(Signed) J. T. Hall M.D.

19 30 (Address) 5001 Gallow Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Mar 15 1930

20 UNDERTAKER A S Marshall 539

ADDRESS Catonsville

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55065

CERTIFICATE OF DEATH

90 ✓ E 55065

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1504 N. Gilmor St. 15-21 Ward)

2-FULL NAME Jennie Neel Stewart

(a) RESIDENCE NO. 1504 N. Gilmor St. 15 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE: Years 50 | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Maggie Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Barbara Brollier
(Address) 1504 N Gilmor St

15 Filed ..... 19.....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis
Sudden
(duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary)
(duration) 2 yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. H. Finch, M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington DC

DATE OF BURIAL 3-15 1930

UNDERTAKER Daniel Easton

ADDRESS Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55066 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55066

CERTIFICATE OF DEATH

REGISTERED NO. 19-27

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Smith

(a) RESIDENCE NO. 7 Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 23, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Mike Branford

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Smith

13 BIRTHPLACE OF MOTHER (city or town) Walkersville
(State or country) Md

14 Informant Marie Smith (Grandmother)
(Address) 7 N Bruce St

15 MAR 1930 C. HARRISON HOMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-30

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to March 12, 1930, that I last saw h[illegible] alive on March 12, 1930 and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 1 ds

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Carroll M St Clair, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 3-15-30

20 UNDERTAKER Kemp & Carton

ADDRESS E 6 Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55067

CERTIFICATE OF DEATH

91-002 E 55067

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Valley St ST. 10-14 WARD)

2—FULL NAME Patrick Fitzpatrick

(a) RESIDENCE NO. Little Sisters of the Poor ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17th 1856

7 AGE: Years 73 | Months 11 | Days 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Fenton & Valley Sts

15 Filed MAR 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1930 to Mar 14, 1930

that I last saw h alive on Mar 13th, 1930

and that death occurred, on the date stated above, at 6½ m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Edmund Wirth, M. D.

3/14 1930 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Mar. 15 1930

20 UNDERTAKER: Rule Riedefeld — ADDRESS: 914 Greenmt Ave

important. See instructions on back of certificates.

R MAR 15 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55068 90 E 55068

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 8 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Jacobs

(a) RESIDENCE NO. 1622 N Milton Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Aug 27th

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Richard Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Richard Jacobs

(Address) 1622 N Milton Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 30

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to March 14th, 1930, that I last saw h e alive on March 14th, 1930 and that death occurred, on the date stated above, at 11 30 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease with mitral stenosis + insufficiency; aortic insufficiency

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Lewis P Gibbes, M. D.

March 14th, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sangerville Ga.

DATE OF BURIAL March 1930

20 UNDERTAKER W Morris Rountree

ADDRESS 2238 W North

IF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS important. See instructions on back of certificates.

C. HAMPSON JONES, M.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55069 (DeWolf) 45 (Rowe) E 55069

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances (DeWolf) Theobald

(a) RESIDENCE NO. 1501 Park Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 0 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Edna (Potter) Delaney

6 DATE OF BIRTH (month, day, and year) March 11, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) $6 0

(c) Name of employer City

9 BIRTHPLACE (~~City or town~~) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Samuel (Theobald)

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline (DeWolf)

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Rhode Island

14 Informant Mrs Frances ~~DeWolf~~ (Wife)

(Address) 1501 Park Avenue

15 Filed APR 5 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 13, 1930, that I last saw h~~im~~ alive on March 13, 1930 and that death occurred, on the date stated above, at 7 05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Mar. 7, 1930

Was there an autopsy? No

What test confirmed diagnosis? Examination at Operation

(Signed) Chas K. Cunningham, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Mar 15th 1930
20 UNDERTAKER Henry A Jenkins Sons Co	ADDRESS McCulloh & Orchard St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55070

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

E 55070

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 825 Washington Blvd St. 24-29 Ward)

2-FULL NAME Martha Ellen McCarthy

(a) RESIDENCE NO. 825 Washington Boulevard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		3	28 17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Burton J. McCarthy

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Elda M Tolson

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Burton J. McCarthy
(Address) 825 Washington Boulevard

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Convulsions ? Grippe

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Brooke M. D.

, 19 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	March 15 1930
20 UNDERTAKER	ADDRESS
John F. Denny	415 S. 14th St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55071

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55071

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4664 Pimlico Rd ST. 27-57 WARD)

2—FULL NAME Richard E. Wildenforst

(a) RESIDENCE NO. 4664 Pimlico Rd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 10 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) May 3 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry F. Wildenforst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore md

12 MAIDEN NAME OF MOTHER Ethel E Snow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Ethel E Wildenforst

(Address) 4664 Pimlico Rd

15 Filed MAR 5 1930 HAMILTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23 1930 to Mar. 13. 1930

that I last saw him alive on Mar. 13. 1930

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis Rheumatic.

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Acute Poly arthritis Rheumatic (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James S. Ashurst, M. D.

3-13. 1930 (Address) 4012 Park Heights av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Mar 17 1930

ADDRESS 715 Light St

20 UNDERTAKER F. B. John & Denny

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55072

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 W Mulberry ST. 15-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Jane Gwinner

(a) RESIDENCE NO. 1207 W Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single, Married, Widowed, or Divorced~~ (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas Harry Gwinner

6 DATE OF BIRTH (month, day, and year) Feb 14 1860

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Joseph A Forsyth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Eliza Ridley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Harry Gwinner

(Address) 1207 W Mulberry St.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1930

17 I HEREBY CERTIFY, That I attended deceased from March 13 1930, to March 14 1930, that I last saw ~~him~~ her alive on March 14 1930, and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Acute

CONTRIBUTORY (Secondary) Senile Degeneration (duration) 5 yrs. mos. ds.

Chronic Nephritis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. L. Beard, M. D.

3/15 1930 (Address) 1901 Fairview Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Mar 17 1930

20 UNDERTAKER Putnam & Love

ADDRESS 1723 W Lafayette Ave

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 55073

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55073

CERTIFICATE OF DEATH

161-001

REGISTERED NO. 13-52

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3828 Hickory Ave ST.) (WARD) 2 of Twins.

2—FULL NAME Baby boy Martin (Born 8 A.M. 3/13/30)

(a) RESIDENCE NO. 3828 Hickory Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/13/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4½ hours	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Martin

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Agnes Luby

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Agnes Martin (Mother)
(Address) 3828 Hickory Ave

15 Filed ..., 19... [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/30

17 I HEREBY CERTIFY, That I attended deceased from 8 A.M. 3/13/30, 1930, to 12:30 P.M. 3/13, 1930, that I last saw him alive on 3/13/, 1930 8:30 A.M. and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Hovey, M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden

DATE OF BURIAL March 14, 1930

20 UNDERTAKER Chenoweth Son

ADDRESS 3615 Chestnut Ave

Important. See instructions on back of certificates.

MAR 14 1930

Part

Spec.—1-30—M. & T.—250 Blks.

E 55074 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 90 E 55074

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3410 Toone ST. 70-1 WARD)

2-FULL NAME Evelyn Davis Jenkins

(a) RESIDENCE No. 3410 Toone ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 17-1906

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or ....min.
	23	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rosa Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Robert Jenkins

(Address) 3410 Toone St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14-1920

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 19 30. to 3-14, 19 30.

that I last saw h[illegible] alive on 3-13, 19 30

and that death occurred on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH was as follows*:

Mitral Regurgitation

(Pneumonia)

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Linda Boyle M. D.

(Address) 3-14-20 3000 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL March 17 19 30

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St

TION is very important See instructions on back of certificates.

Filed MAR 15 1930

Spec.—1-30—M. & T.—250 Blks.

E 55075 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55075

47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3124 Elliott ST. 1 WARD 1)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna A. Ferguson

(a) RESIDENCE NO. 3124 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Washington Ferguson

6 DATE OF BIRTH (month, day, and year) Oct. 23-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown (State or country) Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Anna T. Fecher (Address) 3124 Elliott St

15 Filed 15 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15-1930

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1930, to Mar 15-, 1930, that I last saw h[illegible] alive on Mar 13, 1930, and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) Not Known yrs. mos. ds.

CONTRIBUTORY (Secondary) Rt. Mammary Carcinoma (duration) 20 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phys Exam.

(Signed) Chas J. Keller, M. D.

3/16, 1930 (Address) 222 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL March 18 1930

20 UNDERTAKER George W. Zirkle

ADDRESS 1737 E. Eager St

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55076 146 E 55076

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 16-22 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nettie A. Chase. (C)

(a) RESIDENCE NO. 1711 N. Lanvale St. St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married.

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Chase. (C)

6 DATE OF BIRTH (month, day, and year) January 20, 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	32	1	20 27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Matthew Anderson. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Catlin. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant William Chase. (C) husband.
(Address) 1711 N. Lanvale St.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia.
Self-induced Abortion.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1711 N. Lanvale 3/5/30

Did an operation precede death? No. Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry

(Signed) Otto E. Reinhardt, M. D.

3/14 1930 (Address) 1010 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	3/16 1930
20 UNDERTAKER Samuel T. Hawley	ADDRESS 178 N. Bradford

Spec.—8-16-29—L. F. S.—100 Bks.

E 55077

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55077

CERTIFICATE OF DEATH

51

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 951 Walnut ST. 17-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Raymond Woodward

(a) RESIDENCE NO. 951 Walnut ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coalyard.

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer Self Balto City

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Singleton Woodward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Ridout

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Geo. Woodward

(Address) 908 Bassin av

15 Filed ... 5 1930 ..., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13-930

17 I HEREBY CERTIFY, That I attended deceased from July 25- 1930, to Mar 13- 1930, that I last saw h- alive on Mar 13- 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Endo-myocarditis acute

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Acute rheumatic arthritis (duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No-

What test confirmed diagnosis? Physical exam

(Signed) Chas. J. Keller, M. D.

Mar 15 1930 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3/17 19 30

20 UNDERTAKER Emanuel Hensley

ADDRESS 1118 Bolton

IF DEATH is in plain terms, so that it may be of property claimed. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55078

CERTIFICATE OF DEATH.

101-91

E 55078

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1613 Brunt ST. 15-21 WARD

2-FULL NAME George Daniels

(a) RESIDENCE NO. 1613 Brunt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE: Years 50 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Andrew Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susan Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mother Est 1631 Brunt St.

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/13/30

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1930, to March 13, 1930, that I last saw h.. alive on March 13 1930 and that death occurred, on the date stated above, at 8-20 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) ..... yrs. ..... mos 9 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path.

(Signed) Garland Littlefield M. D.

19 30 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Va

DATE OF BURIAL 3/15 19 30

20 UNDERTAKER Samuel T. Newsley

ADDRESS 1538 Druid Hill Ave

TION is very important See instructions on back of certificates.

MAR 15 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 55079

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55079

CERTIFICATE OF DEATH

× 117 √ É 55079

REGISTERED NO. 17-25

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq Hosp (ST.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Rosenbaum

(a) RESIDENCE NO. New Freedom Pa ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Hand.

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Joseph Rosenbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Wampler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Walter Rosenbaum

(Address) 824 W 32nd St

15 Filed MAR 15 1930 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1930, to March 15, 1930, that I last saw h(im) alive on March 15, 1930 and that death occurred, on the date stated above, at 1 15 A m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Ruptured appendix

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 3/12/30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Arthur Rattenni, M. D.

3/15, 1930 (Address) Franklin Sq Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crockett Va — DATE OF BURIAL March 15 1930

20 UNDERTAKER Chenoweth Lon — ADDRESS 3615 Chestnut ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55030

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mrs. Baker Maryland General Hosp. REGISTERED NO. 118 E 55030

CITY OF BALTIMORE: (No. Howard & Madison ST. 11-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Rebecca C Hopkins

(a) RESIDENCE NO. Colora, Md ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Colora
(State or country) Md

PARENTS

10 NAME OF FATHER Thomas Hopkins

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Hanna Fussel

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Hosp Record
(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to March 15, 1930, that I last saw h alive on March 15, 1930 and that death occurred, on the date stated above, at 1 05 P m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis
Plastic Operation Hernia
Chronic Appendicitis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Yes Date of Mar 11, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H E Kirkpatrick, M. D.

3/15, 1930 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL John F. D Colora Md

DATE OF BURIAL Mar 15 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E.55081 E55081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E.55081 X 38 No. 55081

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. S. 12-49 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Whalen

(a) RESIDENCE NO. Mace Lane + Upper Landing ST., WARD Maryland.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word).
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura M. Whalen

6 DATE OF BIRTH (month, day, and year) Dec. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Stephen Whalen

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Caroline Markell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Laura M. Whalen (wife)

(Address) Mace Lane + Upper Landing Stevenson Md.

15 Filed [illegible] 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1930, to March 15 1930, that I last saw h[illegible] alive on March 15 1930 and that death occurred, on the date stated above, at 6.20 a.m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis, Syphilitic Arteriosclerosis Cirrhosis of Liver

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Cirrhosis of Liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) H. T. Shackelford, M. D.

March 19 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lawn U. Highland Cem Bradshaw Md.	March 18 1930
20 UNDERTAKER Lilly + Gaither Inc.	ADDRESS 402 S. Wolfe St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55082

100-001

E 55082

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospls. REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Mathaney

(a) RESIDENCE NO. 1100 S. Linwood Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Mathaney

6 DATE OF BIRTH (month, day, and year) Oct 1st 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Mathaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth V.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records in Balto City Hospls.
(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14-30

17 I HEREBY CERTIFY, That I attended deceased from 2-21-, 1930 to 3-14, 1930, that I last saw him alive on 3-14-, 1930 and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis & Confusion + Deterioration (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Harry Goldsmith, M. D.

3/15, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	Mar 17, 30
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Important. See instructions on back of certificates.

MAR 16 1930 DAMERON & LENS, INC.

Spec.—2-29-28—L. F. S.—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55083 46 55083 E 55083

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Wm. (Mary) Keating

(a) RESIDENCE NO. 1921 St. Paul St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Wm. Keating (D.)

6 DATE OF BIRTH (month, day, and year) July 4, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER William Duffy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Sophia McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Mrs. Wm. Keating

(Address) 1921 St. Paul St.

15 Filed MAR 16 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 1930, to March 14, 1930

that I last saw h.. alive on March 14, 1930

and that death occurred, on the date stated above, at 11:05 P. m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma of Uterus

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Metastatic Carcinomatosis (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? 1921 St. Paul St.

Did an operation precede death? Yes Date of 10/13/29

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic findings

(Signed) Albert R. Wilkerson, M. D.

March, 1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	3/17 1930
20 UNDERTAKER	ADDRESS
Williams Cook	1217 St. Paul

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 55084 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55084

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 E. Chase ST. 10-14 WARD)

2-FULL NAME Grace E. Wilmer

(a) RESIDENCE NO. 1007 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph C. Wilmer

6 DATE OF BIRTH (month, day, and year) Dec 21, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank A King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Wayne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Lillian E. Weatherstine

(Address) 1802 N. Castle St

15 Filed MAR 16 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/15, 1930, to 3/15, 1930, that I last saw her alive on 3/13, 1930, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of none

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lee Mayer M. D.

3/15, 1930 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mar 18 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 N. Paul

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55085

100-00 55085

E 55085

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. ST. 7231 (WARD)

2-FULL NAME Theodore Waitz

(a) RESIDENCE NO. 823 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aubrey Waitz

6 DATE OF BIRTH (month, day, and year) Jan - 8 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice man

(b) General nature of industry, business, or establishment in which employed (or employer) 0816

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Waitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Hospital Record

(Address)

15 Filed 19 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-10-30

17 I HEREBY CERTIFY, That I attended deceased from 3-10, 1930, to 3-10, 1930, that I last saw him alive on 3-10, 1930, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Benign Prostatic Hypertrophy

(duration) Unknown

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Lumpkin M. D.

3-10, 1930 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL 3/18/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

MAR 16 1930

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55086

181-001 55086

E 55086

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 638 W. Lombard St., 20 Ward)

2-FULL NAME William F. Shaw

(a) RESIDENCE NO. 638 W. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) March 4 - 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	47	0	7	10

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chair-maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bagby Co 014

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. F. Shaw

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Theresa Dixon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Bertie Paca
(Address) 2406 Montebello Ave

15 Filed MAR 16 1930 10 A. M. H. A. [illegible] M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Poisoned by Illuminating gas.
Accidental Death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fillis, M. D.

3/15, 1930 (Address) 2738 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 3/17/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55087

E 55087

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1619 Carswell St., 9-46 Ward)

2-FULL NAME Fredericka Julier

(a) RESIDENCE NO. 1619 Carswell St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Julier

6 DATE OF BIRTH (month, day, and year) April 28/1859

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	70	10	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER ----- Hoffman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) German

14 Informant Ralph G. Sauer
(Address) 1619 Carswell St

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

3/15/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cincinnati Ohio — DATE OF BURIAL Mar 18 1930

20 UNDERTAKER Mr. & Mrs. J. W. Teufel & Son — ADDRESS 801 W Fayette

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 16 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 55088

E 55088 — **CERTIFICATE OF DEATH** — **E 55088**

REGISTERED NO. 15-62

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3725 Belle Ave WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lang Clark

(a) RESIDENCE NO. 3725 Belle Ave ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
(or) WIFE of Thomas C. Clark

6 DATE OF BIRTH (month, day, and year) Mar 16. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) West River
(State or country) Md.

PARENTS

10 NAME OF FATHER John Lang.

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Rosina Loker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Thomas C. Clark
(Address) 3725 Belle Ave.

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 14. 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10th, 1930, to March 14th, 1930, that I last saw her alive on March 14th, 1930 and that death occurred, on the date stated above, at 12.50 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Elbert C. Reitzel M. D.

3/14, 1930 (Address) 3727 Belle Ave. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount.	Mar 17 1930.

20 UNDERTAKER — ADDRESS

Funeral J. W. Teufel & Son 801 W. Fayette

Spec.—1-10-31—M&T—150 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55089

E 55089

CERTIFICATE OF DEATH.

74-001

E 55089

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1760 E North Ave ST.) 8-17 (WARD)

2-FULL NAME Charlotte Bowman

(a) RESIDENCE NO. 1760 E North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (Late) David T Bowman.

6 DATE OF BIRTH (month, day, and year) Apr 8, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	86	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Port Deposit
(State or country) Cecil Co. Md.

PARENTS

10 NAME OF FATHER John R. Figgat.

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country) Roanoke.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs Geo Rutter.
(Address) 1760 E North Ave.

15 Filed ... 19... Registrar

MAR 16 1930 C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 13th, 1930, to March 14th, 1930, that I last saw h alive on March 14th, 1930 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. J. Santee M. D.

, 19 (Address) 1119 N. Milton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem. Freeland Md	Mar 17 1930

20 UNDERTAKER Keller K. McNamee ADDRESS 4414 Free Rd.

BEFORE STARTING TO WRITE, carefully read the following: AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55090

E 55090 — **CERTIFICATE OF DEATH** — 49 **E 55090**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3031 Presstman ST. 16-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie R. Bailey,

(a) RESIDENCE NO. 3031 Presstman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Robert W. Bailey,

6 DATE OF BIRTH (month, day, and year) February 4, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant: Mrs Ellen B Johnson

(Address) 3031 Presstman St

15 Filed MAR 16 1930 C. HAMPSON JOHNS, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 12, 1930, to March 14, 1930, that I last saw h~~er~~ alive on March 14 1930 and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder 4 mos

Myocardial Insufficiency

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. A. V. Lowe, M. D.

19 (Address) 886 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL MAR 17, 1930

20 UNDERTAKER D. Geo. N. Little

ADDRESS 2700 ~~EDMONDSON AVE.~~

important. See instructions on back of certificates.

Spec. 6-9-19—B. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55091

E 55091

CERTIFICATE OF DEATH.

129

E 55091

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Oswego Ave Cpt. St. 5-58 Ward.

2-FULL NAME Sarah M. Gray

(a) RESIDENCE. No. Oswego ave Cpt St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert H. Gray

6 DATE OF BIRTH (month, day, and year) April 18, 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William T. Woodall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Pamelia Bramble

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) Robert H. Gray Oswego ave cpt

15 Filed . 19 . Registrar

MAR 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 3 . 1930 . to March 15 . 1930 . that I last saw her alive on March 14 . 1930 . and that death occurred, on the date stated above, at 7.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis: Pt may have suffered for several years. Heart bld Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Uraemia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary examination

(Signed) G. L. Beasley, M. D.

, 19 (Address) 2237 Belvedere ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL: March 18, 1930

20 UNDERTAKER: Geo. W. Little ADDRESS 220 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55092

CERTIFICATE OF DEATH

E 55092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 735 Edgewood St. (Ward) 16-67

2-FULL NAME Felix B. Conday

(a) RESIDENCE NO. 735 Edgewood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha W. Conday

6 DATE OF BIRTH (month, day and year): Feb 26-870

7 AGE: Years 57 | Months 3 | Days 17 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Hat examiner
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Conday

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Harrington

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant (Address) Martha W. Conday 735 Edgewood

15 Filed [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

(Address) Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: MAR 18 1930

20 UNDERTAKER: Geo N Little

ADDRESS 2700 EDMONDSON AVE.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 18 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55093

E 55093

CERTIFICATE OF DEATH

101-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3901 Southern ave ST. 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E Scott

(a) RESIDENCE NO. 3901 Southern ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 4 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Harry L Scott

6 DATE OF BIRTH (month, day, and year) Oct 21st 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jacob Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elvira Thorne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Harry L Scott

(Address) 3901 Southern ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 13, 1930, that I last saw h[illegible] alive on March 13, 1930 and that death occurred, on the date stated above, at 720 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. dd

CONTRIBUTORY (Secondary) Lobar Pneumonia (Left side)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

3/15/1930 (Address) 472 A Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Mar 17th 1930
20 UNDERTAKER George Schilling & Sons	ADDRESS 1126 E Monument

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55094

REGISTERED NO. E 55094

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Aliceanna ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony Serio

(a) RESIDENCE NO. 1708 Aliceanna ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 35 mos. ds. How long in U. S., if foreign birth? yrs. 35 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace Serio

6 DATE OF BIRTH (month, day, and year): April 14 1876

7 AGE: Years 53; Months 10; Days 29; If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Fruit

(c) Name of employer: of Co

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Ignatius Serio

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Concetta Mariano

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Frank Lo Negro

(Address) 2222 Hough st

15 Filed ..., 19... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13-1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to March 13, 1930, that I last saw him alive on March 13, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 10 hours ds.

CONTRIBUTORY (Secondary): Bronchitis, acute (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. V. Fulco, M. D.

3-13, 1930 (Address) 1112 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: March 16 1930.

UNDERTAKER: Frank V. Pipitone — ADDRESS: 281 E Baltimore st

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

55095

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55095

CERTIFICATE OF DEATH.

51 E 55095

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Aves S. 28-63 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emil Roesch

(a) RESIDENCE NO. 4516 Penhurst Ave ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Roesch.

6 DATE OF BIRTH (month, day, and year): [illegible].

7 AGE: Years 32 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer.

(b) General nature of Industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George J Roesch.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Margaret G McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mary Roesch

(Address) 4516 Penhurst Ave

Filed MAR 16 1930 HARRY H. JONES, M. D. Registrar

BY ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-15 1930.

17 I HEREBY CERTIFY, That I attended deceased from 2-5 —, 1930, to 3-15, 1930,

that I last saw him alive on 3-15, 1930,

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) George Brenny, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Mar 18 1930

20 UNDERTAKER: Harry H Amacost

ADDRESS 4704 Edgewood Ave

Spec.—1-10-21—M&T—1500 Bks.

V 55096

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55096 CERTIFICATE OF DEATH **E 55096**

1-PLACE OF DEATH Sinai Hospital 101-001 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument ST. 20-69 WARD)

2-FULL NAME Baby Edward High Jr

(a) RESIDENCE NO. 448 S Bentalou ST. St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov. 18-1928

7 AGE — Years: 1 — Months: 3 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Edward High

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Lillian McClutchin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Edward High (Address) 448 S. Bentalou St.

15 Filed [illegible], 19 [illegible] Registrar

C. HAMILTON JONES, M. D.

JAN 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/15 1930

17

I HEREBY CERTIFY, That I attended deceased from March 13, 1930, to March 15, 1930, that I last saw him alive on March 15, 1930, and that death occurred, on the date stated above, at 12 30 am.

The CAUSE OF DEATH* was as follows:

Bilater Lobar Pneumonia

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Bilat. Otitis Media

(duration) ? yrs. 0 mos. 6(?) ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. H. Conn, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Nov. 17 1930

20 UNDERTAKER: George L. Schwartz — ADDRESS: 2101 Eutaw Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55097

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55097

CERTIFICATE OF DEATH

E 55097

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St. 25-30 Ward

2-FULL NAME Michael J. Woodward

(a) RESIDENCE NO. Roly. Balt. Co. Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 21 - 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	74	5	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS.

10 NAME OF FATHER David A Woodward

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Josephine Lally

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Mrs W Woodward
(Address) Towson Md

15 Filed ... 19 ... Registrar

MAR 6 1930 C. HAMPSON JONES, M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide by Bichloride of Mercury.

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O'Brooke, M. D.

3/14. 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 3/17 1930

20 UNDERTAKER Robert Brooks & Son — ADDRESS Catham Hollins

Reg'r

Note should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55098 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55098

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5002 Belair Road ST. 27-41 WARD

2-FULL NAME Emma Rebecca Lenz

(a) RESIDENCE No. 5002 Belair ST. Road WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Lenz

6 DATE OF BIRTH (month, day, and year) Jan. 15 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Reuben Bayliss

11 BIRTHPLACE OF FATHER (city or town) Harpers Ferry (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Catharine Ackler

(Address) 5002 Belair Road

15 Filed JAN 16 1930 C. HARRISON JAMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1930

17 I HEREBY CERTIFY, that I attended deceased from 2/18/30 to 3/14/30, 19..., that I last saw h.. alive on 3/14/30, 19..., and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Abscess of Throat

7 days (duration) ..... yrs. ..... mos ..... da.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. A. Cone M.D.

(Address) Cone & Coulter Elvers

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Carlinwood Cemetery	Jan. 17 1930
20 UNDERTAKER	ADDRESS
Frederick Grossmann & Sons	Fullerton

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

✓ 55099.

E 55099 HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 55099

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3009 Weaver ave ST. 27- 44 WARD

2-FULL NAME John L. Mann

(a) RESIDENCE NO. 3009 Weaver ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary V. Mann

6 DATE OF BIRTH (month, day, and year) July 7th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mason Builder
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER John M. Mann
11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany
12 MAIDEN NAME OF MOTHER Margaret Imeller
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs. Mary V. Mann
(Address) 4255 Hayford Rd.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15 1930, to March 13 1930, that I last saw him alive on March 13th 1930, and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:
Gastric Carcinoma

(duration) 1 yrs. ..... mos ..... dys

CONTRIBUTORY (Secondary) Chronic myocarditis
(duration) 5 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No
What test confirmed diagnosis? X-ray.

(Signed) A. K. Goodby M. D.
3-14, 1930 (Address) 4218 Hayford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Luth. Cemetery — DATE OF BURIAL 3/17 1930

20 UNDERTAKER Frederick Lessel — ADDRESS Govans Fullerton

HARRY JONES, M. D.

APR 16 1930

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-081 55100

CERTIFICATE OF DEATH

E 55100

REGISTERED NO. E 55100

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 736 S. Ellwood ave ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Aldon

(a) RESIDENCE NO. 736 S. Ellwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write this word): Maried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alfred Aldon

6 DATE OF BIRTH (month, day and year): Jan 24, 1878

7 AGE: Years 52 | Months 1 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Finland

PARENTS

10 NAME OF FATHER: Jacob Mustonen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Finland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Finland

14 Informant: Mrs. Alfred Aldon

(Address) 736 S. Ellwood ave.

15 Filed MAR 16 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 13-1930

17

I HEREBY CERTIFY, That I attended deceased from March 1st, 1930, to March 13, 1930, that I last saw her alive on March 13, 1930 and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Personal observation

(Signed) Wm Conrad Bode, M. D.

, 19 (Address) 1900 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn — DATE OF BURIAL: Mar. 16, 30

20 UNDERTAKER: John A. Moran — ADDRESS: 3000 E. Balto St.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55101 44 E 55101

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 42-50 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Harry Kelly

(a) RESIDENCE NO. 2228 Barclay St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-18-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69 70	—	2	26	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

066

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Patrick Henry Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Feaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md

14 Informant Miss L. Kelly

(Address) 2206 Barclay St

15 Filed MAR 16 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/30

17 I HEREBY CERTIFY, That I attended deceased from 3/12/30, 19, to 3/14/30, 19, that I last saw h alive on 3/14/30, 19, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 (?) mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy - Microscopic

(Signed) David Jenner, M. D.

3/15/30 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL March 17 19-30

20 UNDERTAKER Mary W Medefield — ADDRESS 501 E 22nd St

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

55102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001

E 55102

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Hill

(a) RESIDENCE NO. 1413 Myrtle Ave ST., WARD New York
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Susie Hill

6 DATE OF BIRTH (month, day, and year) ? 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y. City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wife

(Address) 1413 Myrtle.

15 Filed ..... 19 ..... Registrar

R 1 61839 E.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1930, to March 13 1930, that I last saw h[illegible] alive on March 13 1930 and that death occurred, on the date stated above, at 4 15 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Post Operation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? yes Date of 3/11/30

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & Physical

(Signed) George Mc Donald M. D.

. 19 Address 900 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 3/17/1930

20 UNDERTAKER Mrs Geo. H. Holland — ADDRESS [illegible]

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55103

REGISTERED NO. E 55103

E 55103

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. 1st ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine Gartelmann

(a) RESIDENCE NO. Glenburnie, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dietrich H. Gartelmann

6 DATE OF BIRTH (month, day, and year) Aug 6 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 21

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wilhelm Domhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Dietrich Gartelmann

(Address) Glenburnie Md

15 Filed APR 15 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to March 15, 1930, that I last saw her alive on March 15, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Appendicitis - Acute (duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-15-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. C. Carterfield, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL March 18 1930

20 UNDERTAKER John F Denny — ADDRESS 765 Light St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55104

CERTIFICATE OF DEATH

185 E 55104

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 Hanover ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma J Eason

(a) RESIDENCE NO. 406 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Hiram M Eason

6 DATE OF BIRTH (month, day, and year) Oct 19 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Benjamin Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Priscilla Derpsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Ellen V. Williams
(Address) 406 Hanover st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 25 1930 to March 13 1930.

that I last saw h[illegible] alive on March 13 1930

and that death occurred, on the date stated above, at 10 55 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (Terminal).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured femur, L. Accidental fall down stairway of her home

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? No Inquest necessary

Did an operation precede death? No Date of Otto M. Reinhardt Coroner

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Schmunk M. D.

1930 (Address) 1337 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Mar 17 1930

20 UNDERTAKER John F. Denny

ADDRESS 75 Light

Important. See instructions on back of certificate.

C. HAMPSON JONES, M. D.

MAR 21 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55105 E 55105

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Greenway Apts ST. 12 WARD)

2—FULL NAME William Barney Starris

(a) RESIDENCE NO. Greenway Apts ST. 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs 3 mos 16 ds. How long in U. S., if foreign birth 69 yrs 3 mos 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gertrude Carroll Starris

6 DATE OF BIRTH (month, day, and year): Nov-27-1860

7 AGE: Years 69 | Months 3 | Days 16 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance Broker

(b) General nature of industry, business, or establishment in which employed (or employer): Insurance

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Butts Maryland

PARENTS

10 NAME OF FATHER: Thomas Starris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Butts Maryland

12 MAIDEN NAME OF MOTHER: Isabella Barney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Butts Maryland

14 Informant: Mrs Carroll H. Fisher (daughter)

(Address) 4418 Eastway City

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 15 1930.

17 I HEREBY CERTIFY, That I attended deceased from June 27, to March 15, 1930.

that I last saw h... alive on March 15, 1930

and that death occurred, on the date stated above, at 12 M

The CAUSE OF DEATH* was as follows:

Myocarditis

Hypertension

Cardiac Hypertrophy

Cerebral Hemorrhage (duration) 2 yrs. mos. ds.

CONTRIBUTORY (secondary) Cardiac Dilatation, Pulmonary Edema, (duration) ...yrs. ...mos. 4 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross Findings

(Signed) H. H. Woody, M. D.

, 19 (Address) 140 St Paul ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Mar 17 19 30

20 UNDERTAKER: Edward H. Konrad Co — ADDRESS: Balto.

Important. See instructions on back of certificate.

REC'D 1930 C. HOWARD JONES, M.D.

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55106 E 55106

CERTIFICATE OF DEATH.

127-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1735 Harford Av ST. 9-18 (WARD)

2-FULL NAME George J. Ruth

(a) RESIDENCE NO. 1735 Harford Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary T. Ruth

6 DATE OF BIRTH (month, day, and year) 10-10-1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
56	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank Ruth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Francis Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary T. Ruth
(Address) 1735 Harford Ave

15 Filed MAR 17 1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 9, 1929, to March 13, 1930, that I last saw him alive on March 13, 1930, and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophic Cirrhosis of Liver. (Non alcoholic)

(duration) 1 yrs. mos ..... ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) ..... yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Sept. 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) C. Clute Dingwall M. D.

3/15, 1930 (Address) 613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 3-17-1930

20 UNDERTAKER D. Walter Jenkins

ADDRESS 1637 North Ave

CAUSE OF DEATH must be plainly written, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55107

CERTIFICATE OF DEATH

E 55107

REGISTERED NO. 90

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. 21-54 WARD)

2—FULL NAME Alice Emma Lord.

(a) RESIDENCE NO. Mt Washington Md. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of Mr. Chas. W. Lord.

6 DATE OF BIRTH (month, day, and year) 10-8-48

7 AGE: Years 81 | Months 5 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Peter Sauerwein (d)

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Clarkson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gettysburg, Pa.

14 Informant Mr. Chas. W. Lord.

(Address) Mt Washington Md

15 Filed APR 7 1930

16 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1930, to March 16, 1930, that I last saw h alive on March 16, 1930 and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 212 Park Ave.

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin. Findings

(Signed) Francis W Gluck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: March 18 1930

20 UNDERTAKER: Sturgis Gudelsun & Sons Co.

ADDRESS: Calvert & Fayette

Important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

Frey

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55108

E 55108

CERTIFICATE OF DEATH

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3700 Chesterholme Rd St. 15 Ward)

2-FULL NAME Mrs Dank Virg. Frey

(a) RESIDENCE NO. 3700 Chesterholme Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Lewis Frey

6 DATE OF BIRTH (month, day, and year) Mch. 18th 1853

7 AGE	Years	Months	Days
	77	11	24

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Lewis Frey

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mrs Lewis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs Elizabeth Frey

(Address) 3700 Chesterholme Rd.

15 Filed ..... 19 ..... Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Mch. 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 1930 to Mch 14th 1930

that I last saw h~~e~~s alive on Mch 14th 1930

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Arteriosclerosis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Carcinoma Liver & Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visible

(Signed) Jas Smith, M. D.

3/14 1930 (Address) 1605 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

Date of Burial Mch 18 1930

20 UNDERTAKER Jonah Kyper

ADDRESS 1600 W North Ave

MAR 17 1930

Mch 16 1930 Frey

Mch 18 1930 Frey

Mch 14 1930 Frey

Spec.—1-10-21—M&T—1500 Bks.

E 55109

HEALTH DEPARTMENT—CITY OF BALTIMORE

55109

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital St. 91-56 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Stewart

(a) RESIDENCE No. 3733 Manchester Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of J. Marshall Stewart

6 DATE OF BIRTH (month, day, and year) Nov. 7 - 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	32	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Harvey E. Conely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary E. Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Michigan

14 Informant J. Marshall Stewart

(Address) 3733 Manchester Ave

15 Filed MAR 7 1930 19

C. HAYWARD JONES, M. D. Registrar

Per C.H.J.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR. 14 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-9 1930 to 3-14 1930,

that I last saw her alive on 3-13 1930,

and that death occurred, on the date stated above, at 7 20 a. m.

The CAUSE OF DEATH* was as follows:

APPENDICITIS, SUB ACUTE: UTERINE DISPLACEMENT - PERINEAL LACERATION.

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) PULMINARY EMBOLUS

(duration) — yrs. — mos. 4 MIN ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Yes Date of 3/10/30

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. W. Hoffman, M. D.

, 19 (Address) 8 East Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Mar 17 1930

20 UNDERTAKER Fox & Syfer ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 55110

REGISTERED NO.

1—PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. ST., WARD) 7-13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Tress

(a) RESIDENCE NO. 1084 N. Wash. St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 8 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Arthur Tress

6 DATE OF BIRTH (month, day, and year) 7/14/1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	7 8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Inspector of

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John T. Tress

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Dennis

13 BIRTHPLACE OF MOTHER (city or town) (2) (State or country)

14 Informant Hospital Records.

(Address)

15 Filed APR 17 1930 19 C. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15/30

17 I HEREBY CERTIFY, That I attended deceased from 3/8, 1930, to 3/15, 1930, that I last saw him alive on 3/15, 1930 and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis and nephritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. A. Lane Dennis M. D.

3/15/30 (Address) 1 W. Lan. Hopk.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

DATE OF BURIAL Mar 18 1930

20 UNDERTAKER John Ullrich

ADDRESS Bar & Albemarle

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55111 90 E 55111

CERTIFICATE OF DEATH.

REGISTERED NO.

E 55111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital St. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles B. Knichton

(a) RESIDENCE NO. 1212 E. Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 5 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Painter

(b) General nature of industry, business, or establishment in which employed (or employer) 050

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jos G Knichton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Barranger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Sallie E. Knichton

(Address) 1212 E Federal St

15 Filed C. HAMPSON JONES, M. D. Registrar

APR 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16 1930

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1930, to March 16, 1930,

that I last saw h in alive on March 16, 1930,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis with decompensation

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical findings

(Signed) Lawrence M. Tersa, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Crem.

DATE OF BURIAL 3-19 1930

UNDERTAKER Bernard C Harle

ADDRESS 1000 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55112

CERTIFICATE OF DEATH

31 ✓ E 55112

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 543 E Fort Ave ST. (WARD) 9-4-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John O. Haynes

(a) RESIDENCE NO. 543 E Fort Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Haynes

6 DATE OF BIRTH (month, day, and year) July 3rd 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (City or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Not Known

14 Informant Mary A Haynes

(Address) 543 E Fort Ave

15 Filed MAR 7 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1929, to 3/14, 1930,

that I last saw h[illegible] alive on March 14, 1930

and that death occurred, on the date stated above, at 4.40 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O Mitchell, M. D.

3/14, 1930 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL 3-18 1930

20 UNDERTAKER E & B Hasle

ADDRESS 115 E Fort Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Burck

E 55113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 55113

1—PLACE OF DEATH — REGISTERED NO. 10-69

CITY OF BALTIMORE: (No. 2403 W. Franklin St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa. May Busek

(a) RESIDENCE NO. 2403 W. Franklin WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 10 mos. 5 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Busek.

6 DATE OF BIRTH (month, day, and year): May 10. 188[illegible]

7 AGE — Years: 43 — Months: 10 — Days: 5 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: George Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Emma Nizgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Christina Busek
(Address) 2403 W. Franklin

15 Filed [illegible], 19 — C. HARRISON BURNS, JR. — Registrar

MAR 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 15- 1930

17 I HEREBY CERTIFY, That I attended deceased from February 1- 1929 to March 15- 1930, that I last saw h[illegible] alive on March 14- 1930 and that death occurred, on the date stated above, at 3 [illegible] m.

The CAUSE OF DEATH* was as follows:*

Carcinoma of Breast

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Reland, M. D.

3-17- 1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Mar 18 1930
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	2179 Pa.

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55114

E 55114

CERTIFICATE OF DEATH

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital St., (Ward) 18-26

2-FULL NAME Anna Stewart

(a) RESIDENCE NO. 709 Edmondson Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Stewart

6 DATE OF BIRTH (month, day, and year) Aug. 10 1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
69 70	1930	7 mos	14. 4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Kent Co Md

PARENTS

10 NAME OF FATHER Ben Ringgold

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Kent Co. Md

12 MAIDEN NAME OF MOTHER Earanna Ringgold

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Kent Co. Md

14 Informant (Address) Carrie Adams niece 709 Edmondson ave

15 Filed 19 Registrar

MAR 7 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory Arteriosclerosis (duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Grady M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen Cemetery	Mar 7 1930
20 UNDERTAKER	ADDRESS
Lattie Gross	1402 Ashland Ave

Be sure to carefully answer every question. Write plainly in ink. Any alteration or erasure renders certificate void. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—350 Blks

1217 E North
Bowdoin
31

E 55115 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55115

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2536 Ansgiuk ST., 9-46 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah F. Wilson

(a) RESIDENCE NO. 2536 Ansgiuk ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: John H. Wilson

6 DATE OF BIRTH (month, day, and year): Sept. 29-1866

7 AGE — Years: 63 Months: 5 Days: 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm J Conley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah Moreman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Blanche E Hauser 2527 York Road

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 15/30

17 I HEREBY CERTIFY, That I attended deceased from 12/27 .19 29. to 3/15 .19 30.

that I last saw her alive on 3/6 .19 30.

and that death occurred, on the date stated above, at 10:32 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Sputum + Tbc

(Signed) George Asher Bowdoin, M. D.

3/17 1930 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: 3/17 1930

20 UNDERTAKER: W M Cook

ADDRESS: 1217 E Pratt

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55116

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55116

24-001

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2329 E. Fayette ST. 6-10 (WARD)

2-FULL NAME Fannie V. VanKensley

(a) RESIDENCE No. 2329 E. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos A. VanKensley

6 DATE OF BIRTH (month, day, and year) May 22/57

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
72	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HW 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm Bannett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fannie James

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Paul VanKensley (Address) 2329 E. Fayette St

MAR 17 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1930, to March 17 1930, that I last saw her alive on March 17 1930, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain

(duration) ... yrs. 1 mos 17 ds.

CONTRIBUTORY (Secondary) High Blood Pressure Kidney Trouble

(duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Gleason, M. D.

3/15 1930 (Address) 1907 Harlem Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Mar 19 30

ADDRESS 2016 Orleans St

20 UNDERTAKER Philip Henry

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55117

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55117

100-00

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5508 Stonington ave (ST.) (WARD) 28th Ward

2—FULL NAME George Rudolph Hoffmann

(a) RESIDENCE NO. 5508 Stonington ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 11 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced: (a) HUSBAND of (or) WIFE of: Anna Elizabeth Hoffmann

6 DATE OF BIRTH (month, day, and year): Mar 18 1863

7 AGE: Years 66 | Months 11 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Coal Engineering Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas G Hoffmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna Elizabeth Hoffmann
(Address) 5508 Stonington Ave

15 Filed MAR 17 1930 19.. By ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 15 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-2 1930, to 3-15 1930

that I last saw h. alive on 3-15 1930

and that death occurred, on the date stated above, at 2,30 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Arterio sclerosis.

(duration) over 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? None.

What test confirmed diagnosis?

(Signed) Merritt Sorrell M. D.

3/15 1930 (Address) 3705 Liberty Hts. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Paul's Violetville

DATE OF BURIAL: 3/18 1930

20 UNDERTAKER: E. Weber & Son

ADDRESS: 2503 Edmondson

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55118

CERTIFICATE OF DEATH.

90 ✓ **E 55118**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2323 Barkley St. 47-50 Ward)

2-FULL NAME Flora M. Beall

(a) RESIDENCE NO. 2323 Barkley St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Wm. T. Beall 1865

6 DATE OF BIRTH (month, day, and year) April 30 - 1865

7 AGE	Years	Months	Days 15	IF LESS than 1 day.....hrs. or.....min.
	64.	10	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 67

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. A. Nonnmayer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Anderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New Market Md

14 Informant Wm T. Beall

(Address) 2328 Barkley St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest / Autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Cardiac Dilation & Heart Disease (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J. McSherry M. D. (Coroner)

3/17, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Date of Burial Mar 18 1930

20 UNDERTAKER Josiah Lyter ADDRESS 1600 W North ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55119

CERTIFICATE OF DEATH

129 E 55119

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2501 Jefferson St. W. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Pellicot

(a) RESIDENCE NO. 2501 Jefferson St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hellen M. Pellicot

6 DATE OF BIRTH (month, day, and year) March 30 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Pellicot

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Dresel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hellen Pellicot

(Address) 2501 Jefferson St.

15 Filed [illegible] 19 [illegible] Registrar

C. HAMPS[illegible]

1 7 1930 Pol

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1930

17 I HEREBY CERTIFY, That I attended deceased from [illegible] 1, 1929, to March 15, 1930,

that I last saw h[illegible] alive on March 14, 1930

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Smeak M. D.

(Address) 4708 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	March 1929
20 UNDERTAKER	ADDRESS
Martin W. Diffenbaugh	32 St. Paul

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 551 0

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 E 55120

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1727) Sinai Hospital St 6-9 Ward)

2-FULL NAME Simon Rothstein

(a) RESIDENCE NO. 425 N. Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Rothstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Hirsh Rothstein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jacob Janofsky
(Address) 425 N. Wolf St

15 Filed 1930 19 [illegible] M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncopneumonia-Cardiac Failure

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Impending Uremia

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

3/17/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Washington Road

DATE OF BURIAL 3-17- 1930

20 UNDERTAKER Jack Levin, 1439 E Balto St

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55121

HEALTH DEPARTMENT—CITY OF BALTIMORE

162

E 55121

CERTIFICATE OF DEATH

1—PLACE OF DEATH Hospital for Women of Md. REGISTERED NO. 9-46

CITY OF BALTIMORE: (No. Lafayette & John St., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby girl Cosby

(a) RESIDENCE NO. 1016 Darley Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 90 min.
	✓	✓	1 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ old

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Fred DeForest Cosby

11 BIRTHPLACE OF FATHER (city or town) Phelps,
(State or country) New York

12 MAIDEN NAME OF MOTHER Beth Ariel Dare

13 BIRTHPLACE OF MOTHER (city or town) New York
(State or country)

14 Informant Fred DeForest Cosby

(Address) 1016 Darley Ave.

APR 7 1930 C. HAMPSON JONES, M. D.

Filed ....., 19 ..... Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1930, to March 17, 1930, that I last saw her alive on March 17, 1930 and that death occurred, on the date stated above, at 8.40 a. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) life mos. ds.

CONTRIBUTORY (Secondary) Circulatory failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Earle P. Clemson, M. D.

19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phelps N Y

DATE OF BURIAL March 17 1930

20 UNDERTAKER John A Mitchell & Son.

ADDRESS 1900 Eutaw Place

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55122

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55122

CERTIFICATE OF DEATH

117

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hosp ST. 5-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Preston Young

(a) RESIDENCE NO. 1412 Mary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Ethel Young

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Littleton N. C.

PARENTS

10 NAME OF FATHER Louis Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Marie Manley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Louis Young

(Address) 1412 Mary st.

15 Filed MAR 17 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/14/30

17 I HEREBY CERTIFY, That I attended deceased from 2/26, 1930, to 3/14, 1930, that I last saw him alive on 3/14, 1930, and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

Appendicitis Abscess

Strep Abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lung Abscess

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of 3/1/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) D Harris, M. D.

3/14, 1930 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Littleton N. C.	Mar 17 1930
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1725 Oakland

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55123 ✓ E 55123

2350 132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Stokes

(a) RESIDENCE NO. 820 Ensor St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Stokes

6 DATE OF BIRTH (month, day, and year) May-5-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 52	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa — (State or country)

PARENTS

10 NAME OF FATHER John Banks

11 BIRTHPLACE OF FATHER (city or town) Pa — (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Pa — (State or country)

14 Informant Records — (Address) JOHNS HOPKINS HOSPITAL

Rec'd MAR 17 1930 C. HAMPSON JONES, Registrar

By [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar-15-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to Mar. 15, 1930, that I last saw her alive on Mar. 15, 1930, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure occurring during operation for Nephrolithiasis and pyonephrosis. Immediate (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephrolithiasis + Pyonephrosis left (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of March 15, 1930

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) H. S. Everett, M. D.

3/15, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL Mar 19 1930

20 UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1726 Eastland Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 55124

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55124

CERTIFICATE OF DEATH

179

1-PLACE OF DEATH

City of Baltimore: (No. 3101 E. Biddle St., 8-11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard W. Warington

(a) RESIDENCE NO. 3101 E. Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Warington

6 DATE OF BIRTH (month, day, and year) Feb 27/1908

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	22	0	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn, Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Warington

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mary Warington
(Address) 3101 E. Biddle St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MAR 17 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd degree burns -face-arms-body
Gasoline caught fire-being heated
on stove in garage- mistaken for
water-[illegible]ch 3/30-2023 Pennington Ave (duration) yrs. 0 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Police record etc

(Signed) [signature], M. D.

3/15/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	March 18, 30
20 UNDERTAKER	ADDRESS
Jos. J. Herr	156 E. Luzerne

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-002 E 55125

CERTIFICATE OF DEATH

E 55125

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N Calhoun ST., 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Eleanor Pierpont

(a) RESIDENCE NO. 224 N. Calhoun ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County Md

PARENTS

10 NAME OF FATHER John E Holt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Julia A Dugan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Thomas N. Pierpont
(Address) 224 N Calhoun St

15 Filed ..., 19... C. HAMPSON JONES, M. D., Registrar

APR 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16-1930

17 I HEREBY CERTIFY, That I attended deceased from May, 1925, to March 16, 1930, that I last saw her alive on March 16-, 1930 and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) cerebral Embolism

(duration) 4 yrs. 6 mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) M. A. Jacobs, M. D.

, 19 (Address) 1735 N. Bentalou

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 19 1930
20 UNDERTAKER George F Smith	ADDRESS 153 Hollins

Important. See Instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55126

CERTIFICATE OF DEATH

E 55126

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Homer Taylor

(a) RESIDENCE NO. Glenburnie Md. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara L Taylor

6 DATE OF BIRTH (month, day, and year) Nov 7 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Draftsman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newark N.J.

PARENTS

10 NAME OF FATHER Arthur L Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.J.

12 MAIDEN NAME OF MOTHER Unknown

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Clara L Taylor

(Address) Glenburnie Md

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MAR 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 13, 1930, to Mar. 16, 1930,

that I last saw h.e.(.) alive on Mar. 16, 1930

and that death occurred, on the date stated above, at 2.40 A m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer - ruptured

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Generalized peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Mar. 15, 1930

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George H. Yeager. M. D.

Mar 16 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rochester N Y

DATE OF BURIAL Mar 17 1930

20 UNDERTAKER John F Denny

ADDRESS 25 L. Lombard St

Important. See instructions on back of certificate.

Spec.—2-29-28—I. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 55127

CERTIFICATE OF DEATH

E 55127

REGISTERED NO. 25-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Dorothy Knauss

(a) RESIDENCE NO. Cherry Hill Balto Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
9 mo	0	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Henry Knauss

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Ernestine Kissel

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mother

(Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to March 16, 1930,

that I last saw h[illegible] alive on March 16, 1930

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Croup

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

Tuberculosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of 3-4-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) E. E. Stehlinger, M. D.

, 19 (Address) 1213 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL March 17th 1930

20 UNDERTAKER E. Schlemans & Son

ADDRESS 1039 Hanover

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55128

CERTIFICATE OF DEATH

11-002

E 55128

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Byrd St. ST. 24-34 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Gelhard

(a) RESIDENCE NO. 1708 Byrd St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl A. Gelhard

6 DATE OF BIRTH (month, day, and year) Mar. 4 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Feletz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Costello

(Address) 1708 Byrd St.

Filed MAR 7 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to Mar 12, 1930, that I last saw her alive on Mar 12, 1930, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows: Uremia Coma

(duration) yrs. mos. 3 ds.

CONTRIBUTORY Senility + cystitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

3/6, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 3/17 1930

20 UNDERTAKER I. Fleu McCully

ADDRESS 130 E Fort

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55129

CERTIFICATE OF DEATH.

40 E 55129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St. Agnes Hospital ST. 70-71 WARD)

2-FULL NAME Mrs. May Davis

(a) RESIDENCE NO. 505 Janns Ave. ST. Jayne Av WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) M

5a If married, widowed, or divorced HUSBAND of or) WIFE of Henry Davis

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
45				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife. 37

(b) General nature of industry, business, or establishment in which employed (or employer) Home work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jesse C Trubenbagen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. May Davis

(Address) 505 Janns Ave. City

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16 1930

17 I HEREBY CERTIFY, That I attended deceased from 1-18- 1930 to 3-16-30 19

that I last saw her alive on 3-16- 1930 and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Septic pelvis, Pelvic abscess. Pelvic peritonitis. Acute

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Recto fistula + general

Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? yes Date of 3/1/30 - 2--/30

Was there an autopsy? No

What test confirmed diagnosis? operation, Clinical

(Signed) Andrew H. W. Banellin, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL March 19 1930

20 UNDERTAKER N. McRoulson

ADDRESS 2230 N. Mta

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 17 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 55130

HEALTH DEPARTMENT—CITY OF BALTIMORE

107-003

E 55130

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Mercy Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 4-76 WARD)

2—FULL NAME Wm Haas

(a) RESIDENCE NO. 700 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pearl F Haas

6 DATE OF BIRTH (month, day, and year) Oct 24 87

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Philip Haas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henrietta Wachter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U S.

14 Informant Hospital Records

(Address)

15 Filed MART 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 30

17 I HEREBY CERTIFY, That I attended deceased from 2/17, 1930, to 3/16, 1930

that I last saw him alive on 3/16, 1930

and that death occurred, on the date stated above, at 10 45 A. m.

The CAUSE OF DEATH* was as follows:

Lung abscess, rt. lung.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/14/30

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Wm H. McFaul Jr, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL March 18 1930

20 UNDERTAKER W M Courtney

ADDRESS 2235 N Mtta

Important. See instructions on back of certificates.

Use black ink and write in plain terms, so that it may be properly classified. Each statement of occupation must be

Spec.—1-30—M. & T.—250 Blks.

E.55131 HEALTH DEPARTMENT—CITY OF BALTIMORE E. 5-5131

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST., 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Charvat

(a) RESIDENCE NO. 530 S Bouldy St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie? Charvat

6 DATE OF BIRTH (month, day, and year) January 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Charvat

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown Drury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 4-7, 1930 Registrar C. HAMPSON JAMES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-15-30

17 I HEREBY CERTIFY, That I attended deceased from 9-15-24, 19 to 3-15-30, 19.

that I last saw him alive on 3-15-30,

and that death occurred, on the date stated above, at 11:55 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. ? mos

CONTRIBUTORY (Secondary) Bronchopneumonia (Lobar)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home & Here

Did an operation precede death? Yes Date of

Was there an autopsy? Yes (Partial)

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

3-17, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cremation Londonderry

DATE OF BURIAL 3/18 1930

UNDERTAKER J. Fuchs & Sons

ADDRESS Lola

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

2347105 E 55132 — 126 E 55132

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 18-7b (WARD) (Golden)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Moses

(a) RESIDENCE NO. 1003 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George

6 DATE OF BIRTH (month, day, and year): aug-6-1896

7 AGE — Years: 33 | Months: 7 | Days: 8 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NW 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thomas Scriver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Wanck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch-14-30

17 I HEREBY CERTIFY, That I attended deceased from Mch 6 1930, to March 14 1930, that I last saw h. Or alive on Mar 14 1930 and that death occurred, on the date stated above, at 2 35 A m.

The CAUSE OF DEATH* was as follows:

Peritonitis B coli.

Bronchopneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myomata uteri. c operation.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? Yes Date of March 11, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. S. Everett, M. D.

Mar 14. 1930 (Address) The Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 3-17 1930

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Park.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 ✓ E 55133

2 6 E 9 5 1 55133

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-9 WARD)

2—FULL NAME John L. Sheil

(a) RESIDENCE NO. 3446-E-39th St ST., WARD Cleveland Ohio
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stockkeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Clinic

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Thos - Sheil

11 BIRTHPLACE OF FATHER (city or town) Ohio
(State or country)

12 MAIDEN NAME OF MOTHER Anne Lawler

13 BIRTHPLACE OF MOTHER (city or town) Canada
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 17-30

17 I HEREBY CERTIFY That I attended deceased from Mar. 13, 1930, to Mar. 17, 1930, that I last saw him alive on Mar. 17, 1930, and that death occurred, on the date stated above, at 6 35 a. m.

The CAUSE OF DEATH* was as follows:
Brain Tumor, Duration Unknown

(duration) 15 yrs. mos. da.

CONTRIBUTORY (Secondary) Myocardial failure (duration) ? yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/15/30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Clarence Gardner M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cleveland, Ohio — DATE OF BURIAL Mar 19 1930

20 UNDERTAKER Geo M. Zeis & Son — ADDRESS 811 N Wolfe

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

55134 156 E 55134

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2622 E Oliver ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles F. Mandler.

(a) RESIDENCE NO 2622 E. Oliver ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Amelia Mandler

6 DATE OF BIRTH (month, day, and year) July 29- 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Kerns Transfer Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Mandler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma A. Mandler

(Address) 2622 E. Oliver St.

15 Filed MAR 17 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15-1930

17 I HEREBY CERTIFY, That I attended deceased from March 8th 1930 to March 15th 1930

that I last saw him alive on March 15th 1930

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Septic Anthrotis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. W. Kerns M. D.

19 30 (Address) 4905 Belair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 18, 1930

20 UNDERTAKER Wm. Mrs John W. Powell & Son ADDRESS 201 W. Lafayette St

IMPORTANT. See instructions on back of certificate.

Stac—12-23-21—E.B.R.S.—400 Bks.

E 55135

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55135

CERTIFICATE OF DEATH.

15-95-02

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3016 Walbrook Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Walter Willis Smith

(a) Residence No. 3016 Walbrook Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND) of (~~or WIFE of~~) Mary Smith

6-DATE OF BIRTH (month, day and year) April 11, 1847

7-AGE. 82 yrs. 11 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... retired Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer ..... J. C. Kupp & Sons

9-BIRTHPLACE (city or town) (State or Country). Balto., Md

PARENTS.

10-NAME OF FATHER. John R. Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Eliza Buzzard

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) W. Willis Smith Jr.

(Address) 3016 Walbrook Ave.

15- Filed ..... C. HAMPSON JONES, M. D. Registrar.

R 1 7 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 17, 1930.

17- I HEREBY CERTIFY, That I attended deceased from Aug 14, 1929 to Mar 17 1930 that I last saw him alive on Mar. 17 1930 and that death occurred, on the date stated above, at 12.25 a. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) about 2 yrs mos. ds.

CONTRIBUTORY (Secondary) cardiac failure

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) Geo. H. Kupp M. D.

, 19 (Address) 3030 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL, Mar 19 1930

20-UNDERTAKER. Wm J Buckner Sons — ADDRESS N. & Pa.

Instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55136

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 55136

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3504 Mt. Pleasant Ave. St. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George F. Kohler

(a) RESIDENCE NO. 3504 Mt. Pleasant Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 10 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Kohler

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)

PARENTS

10 NAME OF FATHER George F. Kohler

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Not known

12 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Annie Kohler

(Address) 3504 Mt. Pleasant Ave

15 Filed ..., 19 Registrar

R 1 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10—, 1930, to March 14, 1930, that I last saw h. im alive on March 14—, 1930 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Allen C Beetham, M. D.

3-15-1930 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Mar. 18 1930
20 UNDERTAKER	ADDRESS
Wm. E. Miller & Son	2304 Jefferson St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55137

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55137

CERTIFICATE OF DEATH

REGISTERED NO. 164

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2436 N. Calvert ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Adelia Clayton

(a) RESIDENCE NO. 2436 N. Calvert ST., 12 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 82 yrs. 1 mos. 22 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Polk Clayton

6 DATE OF BIRTH (month, day, and year): Jan-22-1848

7 AGE — Years: 82 — Months: 1 — Days: 24 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town): Elkton
(State or country): Maryland

PARENTS

10 NAME OF FATHER: Jacob Johnson

11 BIRTHPLACE OF FATHER (city or town): Elkton
(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Caroline Brown

13 BIRTHPLACE OF MOTHER (city or town): Elkton
(State or country): Maryland

14 Informant: Miss Ellen C. Clayton
(Address): 2436 N. Calvert St.

15 Filed ..... 19 ..... Registrar

APR 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 16. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to Mch 16, 1930.

that I last saw her alive on Mch 15, 1930

and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

Weakness

(duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) ✓

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. N. Gatonl, M. D.

, 19 (Address) 2413 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Mch 19 1930

20 UNDERTAKER: Stewart & Mowen Co. — ADDRESS: Balto.

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55138

CERTIFICATE OF DEATH

32

~~34915~~ E 55138

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Springer

(a) RESIDENCE NO. 2429 Ashland ST. Ore WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-11-1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	7	5 6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Springer

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Anne Hodeca

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

MAR 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 17-30

17 I HEREBY CERTIFY, That I attended deceased from Mar 13, 1930, to Mar 17, 1930, that I last saw him alive on Mar 17, 1930 and that death occurred, on the date stated above, at 9 45 a. m.

The CAUSE OF DEATH* was as follows:

Acute generalized tuberculosis
Tuberculoma of brain
Tuberculosis of meninges
(duration) ....yrs. mos. 18 da.

CONTRIBUTORY (Secondary)
(duration) ....yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) R. O. G. Warren, M. D.

Mar 17. 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer

DATE OF BURIAL Mar. 20 1930

20 UNDERTAKER August Pasch

ADDRESS 2406 Ashland Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55139

E 55139

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore (No. East Falls Ave Foot of Lanvale St., Ward)

2-FULL NAME Unknown

(a) RESIDENCE NO. " " St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning (Acc Prob)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY
(Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Grades, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
PUBLIC CEMETERY

DATE OF BURIAL
19

20 UNDERTAKER
Commissioner Health.

ADDRESS

MAR 17 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55140 198 **E 55140**

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 4-30 W.

2-FULL NAME Rufus Taylor

(a) RESIDENCE NO. 626 W. Redwood St. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant .....

(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to stab wound of left lung & aorta.

Homicide (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eugene Feltis M. D. (Coroner)

3/16. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? .....

626 W. Redwood St.

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

Date of Burial 19

20 UNDERTAKER

ADDRESS

Commissioner of Health.

MAR 1 1930

WOODALL

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 55141 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55141

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (No.) 10-13 (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Jennie Johnson

(a) RESIDENCE NO. 803 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown 67

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cambridge Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Records of Balto. City Hospitals UNIV

15 Filed MAR 17 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-13-30

17 I HEREBY CERTIFY, That I attended deceased from 3-11-30, 19 , to 3-13-30, 19 ,

that I last saw her alive on 3-13-30, 19 ,

and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. over 3 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warwick W. McKean, M. D.

3-15, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health,

ADDRESS

MAR 17 1930

R 17 1930 4:58 RBB

Spec.—1-30—M. & T.—250 Blks.

E 55142 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55142

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ST 58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaiah Carter

(a) RESIDENCE NO. 129 Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Carter

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jamaica

PARENTS

10 NAME OF FATHER Simon Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica

12 MAIDEN NAME OF MOTHER Rosa Fabian

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica

14 Informant Records of (Address) Balto. City Hospitals

15 Filed ... 19 4-15-30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-12-30

17 I HEREBY CERTIFY, That I attended deceased from 1-21-30, 19..., to 3-12-30, 19...,

that I last saw h... alive on 3-12-30, 19...,

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McLean, M. D.

3-12, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

UNIVERSITY OF MARYLAND
MAR 17 1930

Spec.—1-30—M. & T.—250 Blks.

E 55143

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55143

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T. B.) 4-25 31

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Taylor

(a) RESIDENCE NO. 664 W. Fayette st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Taylor

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Marian Schaffer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address) UNIVERSITY OF MARYLAND

15 Filed 7 1930 19 1160 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 ..., 19 29, to March 13, 19 30,
that I last saw him alive on March 13, 19 30,
and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Shroll Jr, M. D.

3-14 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL MAR 17 1930

20 UNDERTAKER Commissioner Health

ADDRESS

TION is very important. See instruction on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 55144 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55144

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. 3-5 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Lawton

(a) RESIDENCE NO. 817 E.Pratt st. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Feb. 1, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER William Lawton

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Anna Donovan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Hospital Records (Address) UNIVERSITY OF MARYLAND

15 Filed ..... 19 ..... Registrar

1461

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1930, to March 13, 1930, that I last saw him alive on March 13, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Donovan Jr M. D.

3-13, 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. ADDRESS MAR 17 1930

MAR 17 1930 C. HAMPSON JONES, M. D.

Per Wm E. WOODALL.

TION IS very important. See instructions on back

Spec.—1-30—M. & T.—250 Bks.

E 55145 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55145

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 15-23 ST. WARD

2-FULL NAME Charles E. Bells

(a) RESIDENCE NO. 1302 Laurens ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Bells

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pool room work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Fred. Bells

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Gertrude ?

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Records of (Address) Balto. City Hospitals

15 Filed MAR 7 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16-30

17 I HEREBY CERTIFY, That I attended deceased from 11-4-29, 19, to 3-16-30, 19,

that I last saw him alive on 3-16-30, 19,

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Diffuse

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

3-17, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 3/21/30

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1601 Druid Hill Ave

Spec—12-23-21—E.B.R.S.—400 Lbs.

E 55146 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55146

CERTIFICATE OF DEATH.

1724 31

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 753 Dolphin St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Leon Hall

(a) Residence No. 753 Dolphin St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ? 1893

7-AGE. 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer). 086

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Josiah A. Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Clara E. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Joseph Hall (Address) 753 Dolphin

15- Filed 192 Registrar

1 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 16/1930

17- I HEREBY CERTIFY, That I attended deceased from February 21st 1930 to March 16 1930 that I last saw him alive on February 6th 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical finding

(Signed) Emmett Fargo M. D.

, 19 (Address) 2937 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery — DATE OF BURIAL. 3/18/30

20-UNDERTAKER, Mrs. Chas. E. Holland — ADDRESS 1631 Druid Hill Ave

In plain terms, as directed by instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55147

E 34401
E 55147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2—FULL NAME Mary Bonat

(a) RESIDENCE NO. Hummelstown ST., Pa — WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Fred —

6 DATE OF BIRTH (month, day, and year) Unknown 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Family (Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 —

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1930, to Mar 17, 1930, that I last saw h alive on Mar 17, 1930 and that death occurred, on the date stated above, at 9 30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

Unknown (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Mar 11, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Operation Urine Autopsy

(Signed) J. J. Snyder, M. D.

, 19 (Address) Johns Hopkins Hosp —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Penna	3-17-30
20 UNDERTAKER Wm Cook 1217 H	ADDRESS Bmc

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55148

E 55148

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1218 S. Decker Ave St. 1-1 Ward)

2-FULL NAME Jan S Skotarski

(a) RESIDENCE NO. 1218 S. Decker Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Skotarski

6 DATE OF BIRTH (month, day, and year): July 28 1894

7 AGE: Years 36 Months 7 Days 15 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tinner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Copper Works. Balto

9 BIRTHPLACE (city or town):

(State or country): Md

PARENTS

10 NAME OF FATHER: Joseph Skotarski

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs. Skotarski

(Address) 1218 S. Decker Ave

15 Filed _____, 19____ Registrar

7 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Acute Alcoholism

(duration) ___ yrs. ___ mos. 1 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) A C Stader M. D.

(Coroner)

19 (Address) 1 E 33 St Wm Gray

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Nicholas Cem

Date of Burial: Mar. 18 1930

20 UNDERTAKER: Stephen J. Fralkowski

ADDRESS: 1018 S. Kenwood Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55149

CERTIFICATE OF DEATH

101-001

E 55149

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6706 Youngstown ave ST. 47-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose Gebhardt

(a) RESIDENCE NO. 6706 Youngstown ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 54 mos. ds. How long in U. S., if foreign birth? yrs. 50 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of William Gebhardt

6 DATE OF BIRTH (month, day, and year) April 13, 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER [redacted] Unk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lillian G. Bruns

(Address) 3115 McElderry St

15 MAR 17 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1930, to March 14, 1930, that I last saw h er alive on March 14, 1930 and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

[redacted]

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M. Schlieder, M. D.

3/16, 1930 (Address) 3307 Eastern Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL March 18 1930

20 UNDERTAKER Frank V. Lipsitz

ADDRESS 2815 E. Baltimore

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55150

46 E 5515 0

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1311 E Federal ST., 9-18 WARD)

2—FULL NAME Katherine Mayfort

(a) RESIDENCE NO. 1311 E Federal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? [redacted] yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced [redacted] (or) WIFE of Martin Mayfort dr

6 DATE OF BIRTH (month, day, and year) February 28 1844

7 AGE: Years 89 | Months — | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John D Kneisler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Mayfort

(Address) 3817 Kuerbert ave

15 Filed MAR 17 1930 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 15th 1930

17

I HEREBY CERTIFY, That I attended deceased from 2nd 18th, 1930, to 3rd 15th, 1930

that I last saw h[redacted] alive on 3rd 11th, 1930

and that death occurred, on the date stated above, at 11.55a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Age (89) Myocarditis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical

(Signed) D. A. Waldran, M. D.

, 19 (Address) 210 East Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: Mar 18th 1930

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 1156 E Monument St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 55151

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55151

CERTIFICATE OF DEATH

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Little Sisters of Poor St., 10-14 Ward)

2-FULL NAME Cora Justies

(a) RESIDENCE NO. Preston & Valley St., Ward

(Usual place of abode) 25 (If non-resident give city or town and State)

Length of residenre in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	79			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Mobile Ala.

PARENTS

10 NAME OF FATHER Charles Gibson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ala

12 MAIDEN NAME OF MOTHER Elizabeth Weaver

13 BIRTHPLACE OF MOTHER (city or town) Ala
(State or country)

14 Informant Little Sisters of Poor
(Address) Valey & Preston

15 Mar 17 1930, 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure-Senility
Fract hip Jan 3/30. Accidently
slipped on floor of home of Littl
Sisters of Poor (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

3/17/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL Mar 18 1930

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Greenmount Ave

R 1 7 1930

Apps

Form should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

(Vavrina)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55152

CERTIFICATE OF DEATH

77 E 55152

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore City Jail. St., 76-42 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank V. Vavrina.

(a) RESIDENCE NO. 4605 Bayonne Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Vavrina.

6 DATE OF BIRTH (month, day, and year) March 28, 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	28	11	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John F. Vavrina.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Carrie M. Broz.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bohemia.

14 Informant John F. Vavrina. (father)
(Address) 4607 Bayonne Ave.

15 Filed ..... 19... C. HAMPSON JONES, M. D. Registrar

1 1930 per ..... NRD

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Depressive Psychosis.

Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

3/17. 1930 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill — DATE OF BURIAL May 8 1930

20 UNDERTAKER Grant Brace Son 1900 Eutaw — ADDRESS Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55153

90 E 55153

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 E Fayette St. WARD) 11th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christina Ritter

(a) RESIDENCE NO. 2009 E Fayette St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leo Ritter

6 DATE OF BIRTH (month, day, and year) Oct 17 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER John Bowers

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Gertrude Keith

(Address) 2009 E Fayette St

15 Filed C. HAMPSON JONES M. D. 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30 '26, to March 16, 1930,

that I last saw her alive on March 16, 1930,

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? Yes Date of Feb. 10, 1930

Was there an autopsy? No Hemorrhoids

What test confirmed diagnosis? Clinical

(Signed) Samuel B. Wolfe, M. D.

3/17 1930 (Address) 1331 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	1930 Mar 19 20
20 UNDERTAKER W. E. Dippold	ADDRESS 371 Cromwell

Important. See instructions on back of certificate.

MAR 17 1930

Spec.—1-10-21—M&T—1500 Blks.

E 55154

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55154

CERTIFICATE OF DEATH.

52

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ella Webber

(a) RESIDENCE No. 1208 Eugene Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Webber

6 DATE OF BIRTH (month, day, and year) 3/17/1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	76	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salisbury Md.

PARENTS

10 NAME OF FATHER Louis D. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alex. Va.

12 MAIDEN NAME OF MOTHER Alice Dodge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass

14 Informant Mr. Cole

(Address) 1202 E. Federal St.

15 Filed 7 1930 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1930, to March 13, 1930, that I last saw h alive on March 13, 1930, and that death occurred, on the date stated above, at 7 35 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure Rheumatic Cardiac disease

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) W B Schneider, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 1/16/30, 19

20 UNDERTAKER Mary I. Ruth Gray

ADDRESS 1935 W. Fay St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT INFORMATION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55155

CERTIFICATE OF DEATH.

100-901

E 55155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 654 W. Saratoga St. 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cascio

(a) RESIDENCE No. 654 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Maria Battaglia

6 DATE OF BIRTH (month, day, and year): June 27th 1891

7 AGE: Years 38. Months 8 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fruit Dealer

(b) General nature of Industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Joseph Cascio

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Cometta Ringuso

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Anthony Cascio

(Address) 632 W. Saratoga St.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/17th 1930

17

I HEREBY CERTIFY, That I attended deceased from March 11, 1930, to March 16, 1930,

that I last saw him alive on March 16, 1930,

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. L. Tumminello, M. D.

, 19 (Address) 306 N. Greene St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: 3/20 1930

20 UNDERTAKER: Mary I. Fowler

ADDRESS: 1735 Harford Ave

TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 55156 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55156

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4990 Dennyse Ave 27-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Adamo

(a) Residence No. 4990 Dennyse Ave St., Ward

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (write the word): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Joseph Adamo

6-DATE OF BIRTH (month, day and year): June —

7-AGE: 50 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Italy

PARENTS.

10-NAME OF FATHER: Peter Puleo

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Italy.

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Italy.

14-(Informant): Joseph Adamo

(Address):

15- C. HAMPSON JONES, M. D. Registrar.

1930 Pat Rest

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Mch. 15-30

17- I HEREBY CERTIFY, That I attended deceased from Mch 15— 1930 to Mch 15— 1930

that I last saw h. alive on Mch 15— 1930

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Bilateral Lung (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 2007 W. Pratt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL, 3/19/30

20-UNDERTAKER: Margaret J. Flynn ADDRESS 1422 Eight St.

instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

2 E 42 6 / 55152 — X 36-804 — E 55157

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Maeser

(a) RESIDENCE NO. Blackwood ST. 11-8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4 1920 Baltimore

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phila Pa.

PARENTS

10 NAME OF FATHER Alfred C Maeser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 7 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1930 6 P.M.

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930, to Mar 17, 1930, that I last saw him alive on Mar 17, 1930 and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of R. Kidney & urinary bladder.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of March 15, '30.

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) E. E. Jones, M. D.

, 19 (Address) Johns Hopkins Hosp Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Blackwood New Jersey	March 18 1930

20 UNDERTAKER Frederick Lees & Son ADDRESS Fullerton

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55158

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) St Agnes Hosp. St. 25-72 Ward)

2-FULL NAME Joe N. Posey

(a) RESIDENCE NO. Potomac Md St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22-1902

7 AGE	Years	Months	Days	IF LESS than 1 day, hrs. or min.
	27	9	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer) Hauling
(c) Name of employer Potomac

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Chas. Posey

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Molly Huff

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant M E Pumphrey
(Address) Rockville Md

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Thrown from swift by
Moving auto in which he was
a rider when it struck culvert
of Bridge H (duration) yrs. mos. ds.

CONTRIBUTORY Fract Skull
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted? Dash. Rd at Savage
If not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) C J Frame, M. D.
3-17 1930 (Address) 7939 Mt Elden

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville Md

DATE OF BURIAL 3-17-1930

20 UNDERTAKER M E Pumphrey

ADDRESS Rockville Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 55159

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55159

CERTIFICATE OF DEATH.

REGISTERED NO. 59-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1514 E. Hoffman ST., 8-17 (WARD)

2-FULL NAME Lizzetta Dorothy Thelen

(a) RESIDENCE NO. 1514 E Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/4/1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ditto

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Thelen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Grace Emory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Grace Emory

(Address) 1514 E Hoffman ST

15 Filed 3 17 1930 19 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/30

17 I HEREBY CERTIFY, That I attended deceased from Mch-16- 1930 to Mch-17 1930,

that I last saw her alive on Mch 17 1930,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Patent foramen Ovale

(duration) yrs. 1 mos 13 da.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) E Gill Hall M. D.

Mch 17 1930 (Address) 1631 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys (Hampden) DATE OF BURIAL 3/18/1930

20 UNDERTAKER Wm Cook 127 ADDRESS St Paul St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55160

E 55160

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3302 Dupont ST. 15 WARD 56

2-FULL NAME Frank L Hartzell

(a) RESIDENCE NO. 3302 Dupont Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Virginia M (Carter) Hartzell

6 DATE OF BIRTH (month, day, and year) Dec 12, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer General Electric

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Frank L Hartzell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Annie L McAbee

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Gordon Wareham
(Address) 5362 Eastern Ave

15 Filed ..., 19 ... Registrar

C. HAMPTON DAVIES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 17, 1930, that I last saw him alive on March 17, 1930, and that death occurred, on the date stated above, at 1.25 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. ... mos. 11 da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. ... mos. 3 da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) Fred B Jewett, M. D.

March 17, 1930 (Address) 2516 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 3/20/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

CAUSE OF DEATH to plain terms, so that it may be properly
TION is very important. See instructions on back of certificates.

17 1930

Spec.—1-10-21—M&T—1500 Bks.

E 55161

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55161

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves ST. 15 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton Shaeffer

(a) RESIDENCE NO. 1709 McKean Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 44 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Wm Steigler

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Andrew Shaeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Sister) Mrs McNally

(Address) 1715 McKean Ave

15 C. HAMPSON JONES, M. D. Registrar

1 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16 1930

17

I HEREBY CERTIFY, That I attended deceased from 3-11, 1930, to 3-16, 1930,

that I last saw h alive on 3-16, 1930,

and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) tuberculous meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) George Brenner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 3/19/1930

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul St

CAUSE OF DEATH to be plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55162

CERTIFICATE OF DEATH.

31 E 55162

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital St. 1-3 WARD)

2-FULL NAME Hazel Milwicz Marie Hazel Milwicz

(a) RESIDENCE NO. 2207 E Pratt St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Steven Milwicz

6 DATE OF BIRTH (month, day, and year) Aug 29 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 027

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Whalen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Anna A Perina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Steven Milwicz (Address) 2207 E Pratt St.

15 Filed ..... 1930 12 by ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/15/30 19

17 I HEREBY CERTIFY, That I attended deceased from 3/6/30, 19..., to 3/15/30, 19..., that I last saw her alive on 3/15/30, 19..., and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows: stricture commun bile duct

(duration) yrs. 8 mos. ... da.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. ... mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/14/30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) ..... M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: March 18 1930

20 UNDERTAKER: John M Weber ADDRESS 401 S Chester St

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55163

CERTIFICATE OF DEATH

170 E 55163

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Hotel Plaza.

City of Baltimore: (No. Charles & Mt Royal Ave. St. 2-4 Ward)

2-FULL NAME Stanley Nosal.

(a) RESIDENCE NO. 16 S. Cheaster St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	87	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER Valentine Nosal.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Sophia Kurek.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Joseph Nosal (brother)
(Address) 721 Clinton Ave Covens.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pistol shot wound of the head.
Suicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhard M. D.

3/17. 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Mount	19 1930
20 UNDERTAKER	ADDRESS
John M Weber	401 E Chester St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55164 ✓ E 55164

E 55164 31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals 6-9 WARD)

CITY OF BALTIMORE: (NO. ST.

2-FULL NAME Henry Washington (Washington Henley)

(a) RESIDENCE NO. 1617 Mullikin st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 Filed ... 19 ... Registrar

TION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 19 30, to March 14, 19 30, that I last saw him alive on March 14, 19 30, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thomas Jr. M. D.

3-15, 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL 3-18, 1930

20 UNDERTAKER James A Hayes

ADDRESS 142 W. Hill

MAR 14 1930 C. H. JONES M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 129 ✓ E 55165

E 55165

REGISTERED NO. 12-50

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 E. 23rd ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Bell Bartgis

(a) RESIDENCE NO. Frederick Maryland ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	widow

a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John C. Bartgis

6 DATE OF BIRTH (month, day, and year) Jan. 24-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	70	2	16	18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Middletown (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Grove

11 BIRTHPLACE OF FATHER (city or town) Middletown (State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Shaffer

13 BIRTHPLACE OF MOTHER (city or town) Middletown (State or country) Md.

14 Informant Mrs. P. S. Russell (Address) 511 E. 23 St.

15 Filed ... 19 ... C. HAMPSON JONES, M. D., Registrar

MAR 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 17-1930

17 I HEREBY CERTIFY, That I attended deceased from Feby 12, 1930, to Mar. 17, 1930, that I last saw h alive on Mar 17. 1930 and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Frederick Md.

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

3/17 1930 (Address) 1663 W. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md

DATE OF BURIAL 3-18-30

20 UNDERTAKER [illegible] ADDRESS 1217 St Paul

Spec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 55166

CERTIFICATE OF DEATH

E 55166

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 W. Hill ST. 72-30 WARD)

2—FULL NAME James E Gibbs

(a) RESIDENCE NO. 16 W. Hill ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

6 DATE OF BIRTH (month, day, and year) Feb 7 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Scott D. Gibbs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Martinsburg W. Va.

12 MAIDEN NAME OF MOTHER Lucy E Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md

14 Informant Scott D. Gibbs
(Address) 16 W. Hill St

15 FILED 1 8 1930 C. HARRISON JONES, M. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 13, 1930, to Mar 16, 1930, that I last saw him alive on Mar 16, 1930 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) Wm Seabury, M. D.

3/17, 1930 (Address) 636 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL March 19 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55167

CERTIFICATE OF DEATH

57 E 55167

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 950 N. Gilmor ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine E. Klingenstein

(a) RESIDENCE NO. 950 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Charles S. Klingenstein

6 DATE OF BIRTH (month, day, and year) Mar 17-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	47	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wolfgang Hecht

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Liz Westerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles E. Klingenstein (Address) 950 N. Gilmor

15 Filed MAR 18 1930 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 17/30

17 I HEREBY CERTIFY, That I attended deceased from January, 1930, to Mar 17th, 1930, that I last saw h[er] alive on Mar 16, 1930 and that death occurred, on the date stated above, at 5.30 m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cons.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. Whitt M. D.

3/17 1930 (Address) 2800 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edwards Cem.

DATE OF BURIAL: 3/19/30

20 UNDERTAKER: H Henry Lutz

ADDRESS: 1203 Broadway

Important. See instruction on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

55168

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1329 E 55168

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 N. Milton Ave 18-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August D. Alpers

(a) RESIDENCE NO. 1103 N. Milton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Alpers

6 DATE OF BIRTH (month, day, and year) Apr. 13/1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
77	78	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Sign Builder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER -- Alpers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria --

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant A. D. Alpers

(Address) 1103 N. Milton Ave

1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 26 1930, to March 15 1930,

that I last saw h[illegible] alive on March 15 1930,

and that death occurred, on the date stated above, at 1 04 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) Pneumonitis yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Thos Jungerman M. D.

5/16/1930 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL May 18 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2006 Eutaw St

TION IS VERY Important. See instructions on back of this

Cor.—10-10-29—A Co.—100 Blks.

55169

HEALTH DEPARTMENT—CITY OF BALTIMORE

55169

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) St Agnes Hosp St., 25-72 Ward)

2-FULL NAME Samuel Mathews

(a) RESIDENCE NO. Washington D C St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	23	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Washington D C
(State or country)

PARENTS

10 NAME OF FATHER Bernard Mathews

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Rissellaff

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant B. Dazynsky
(Address) Washington D. C.

15 Filed MAR 18 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Thrown from speeding auto when it hit culvert

* (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Largo + Wash Rds

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Fraun M. D.

3/18, 1930 (Address) 2139 N. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C	3/18 1930
20 UNDERTAKER Jack Lewis 1439 E Baltimore	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec. 130—M. & T.—250 Bks.

E 55170 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-001 E 55170

CERTIFICATE OF DEATH.

REGISTERED NO. 26-36

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6553 St Helena ST.

2-FULL NAME John Russell Glenn

(a) RESIDENCE NO. 6553 St Helena ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Henry J Russell

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Helen Wellins

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Henry J Russell
(Address) 6553 St Helena Ave

15 Filed C. HAMILTON JONES, M. D.
Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17-30

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to March 17, 1930, that I last saw him alive on March 15, 1930, and that death occurred, on the date stated above, at 5 40 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Atelectasis)

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A W Reiss M. D.

3/17, 1930 (Address) Dundalk, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Saint Matthews — DATE OF BURIAL Mar 18 1930

20 UNDERTAKER John Wellins — ADDRESS 2008 Orleans

Spec.—1-30—M. & T.—250 Bks.

E 55171 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 55171

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Garrison Ave. ST., 15-61 WARD)

2-FULL NAME Annie Carson Hutchins

(a) RESIDENCE NO. 2309 Garrison Ave. ST., ... WARD .....

(Usual place of abode) life (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. T. Hutchins

6 DATE OF BIRTH (month, day, and year) Mar. 25, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Jolin Carson

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Hall

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Marie W. Bradley

(Address) 2309 Garrison Ave.

15 Filed MAR 18 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1930, to March 16, 1930, that I last saw h[illegible] alive on March 16, 1930, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted ..... If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No What test confirmed diagnosis? Physical

(Signed) W. S. Willett, M. D.

3/17/30 19 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Mar. 18 19 30

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

John O. Mitchell

TION is very important. See instruction on back of Certificate

Spec.—1-30—M. & T.—250 Blks.

E 55172

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55172

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 W. Lanvale St. ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgianna M. Uhler

(a) RESIDENCE NO. 1528 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 18, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER George W. Uhler

11 BIRTHPLACE OF FATHER (city or town) Balto., (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna M. Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Grace E. Uhler

(Address) 1528 W. Lanvale St.

15 Filed MAR 18 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16/30

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to March 16, 1930, that I last saw h alive on March 15, 1930, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH[a] was as follows:

Cold

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 4 days.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) V. M. Lanciperia, M. D.

, 19 (Address) 3409 Callaway Ave

[a]State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar. 18, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

HAMSON JONES, M. D.

John O. Mitchell & Sons

TION is very important. See instruction on back of this Certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E55173 . HEALTH DEPARTMENT—CITY OF BALTIMORE E55173

CERTIFICATE OF DEATH

REGISTERED NO. 159

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 N. East ave ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer F. Flannery

(a) RESIDENCE NO. 118 N. East ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 12, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elmer Leo. Flannery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Frances E. Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Elmer L. Flannery

(Address) 118 N. East ave

15 Filed ... 19 ... H. ... JONES, M. D. (Registrar)

MAR 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Mar 12, 1930, to Mar 17, 1930, that I last saw him alive on Mar 16, 1930 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Congenital Cephalic Malformation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) G. M. Lossiek, M. D.

19 (Address) Sparrows Point

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL Feb. 18, 1930

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55174

CERTIFICATE OF DEATH

E 55174

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 E. 23rd ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Byrd

(a) RESIDENCE NO. 311 E. 23rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Byrd.

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ashland
(State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Minnie Byrd.
(Address) 311 E. 23rd st.

15 Filed MAR 18 1930, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14, 1930, to March 15, 1930, that I last saw h[illegible] alive on March 14, 1930 and that death occurred, on the date stated above, at 12 10 A.M.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis
from Carcinoma of Stomach

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) General Conditions

(duration) yrs. mos. 30 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) H. H. Hale, M. D.

19 (Address) 426 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashland Va

DATE OF BURIAL March 18 30

20 UNDERTAKER Mrs. P. G. Elliott

ADDRESS Ashland

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55175

CERTIFICATE OF DEATH

129 E 55175

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 W 37th St. ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Redman

(a) RESIDENCE NO. 902 W 37th St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Late) Edward McRedman

6 DATE OF BIRTH (month, day, and year) Nov 6, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Carr Bailey Nalle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Ridgaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Miss Bertha F. Redman

(Address) 902 W 37th St

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar

MAR 18 1930 C. By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 1st, 1930, to Mar 15, 1930, that I last saw her alive on Mar 15, 1930, and that death occurred, on the date stated above, at 10 30 p.m.

The CAUSE OF DEATH* was as follows: Chronic myocarditis

Intestinal obstruction.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Hampson Jones, M. D.

3/17, 1930 (Address) 846 W 36th St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL March 18 1930

20 UNDERTAKER Chenowith Son

ADDRESS 3615 Elmerton Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55176

CERTIFICATE OF DEATH

199 ✓ E 55176

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto. City Hosp 16-37 St.) (Ward)

2-FULL NAME Pasquelle Matrecami

(a) RESIDENCE NO. 601 Lehigh St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Don't Know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) S. P. Mills
(c) Name of employer Bird Steel

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Sabastian Matrecami

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Athanasia Costos

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant James Fronta
(Address) 350 E. Pratt St

15 Filed MAR 18 1930 C. H. Jones Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & knocked down by speeding auto
H.

I (duration) yrs. mos. ds.
Fract Skull C C

CONTRIBUTORY (Secondary)
Mult. plc. C. C. Fract (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eastern & Aliceson

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. J. Frame, M. D.

3/16 1930 (Address) 2939 W. Fredrick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL March 20.

20 UNDERTAKER Wendell J. Heppel

ADDRESS 307 N. Eden

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55177

181-001

E 55177

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 253 S Caroline St. 3-4 Ward)

2-FULL NAME Eugene R Pinnardina

(a) RESIDENCE NO. 253 S Caroline St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept. 4 1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Inspector
(b) General nature of industry, business, or establishment in which employed (or employer) Tex. Mill
(c) Name of employer Sparrow Point

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER Salvatore Matricciano

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Philomena Carrara

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Mendel J Keppel
(Address) 300 S Eden St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1930.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Acc

Pneumonia Lac Lt.

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 10 30

20 UNDERTAKER Mendel J Keppel

ADDRESS 300 S Eden

How should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55178

REGISTERED NO. 3/ E 55178

1-PLACE OF DEATH

City of BALTIMORE: (No. 135 W Hill St. 7231 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oliver Bowley

(a) RESIDENCE NO. 135 W Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	39	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Steamship Co

(c) Name of employer C. Oleander's

9 BIRTHPLACE (city or town) .....

(State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) unknown

14 Informant Henrietta Logan

(Address) 135 W Hill St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Mar. 14 1930

17

I HEREBY CERTIFY, That I attended deceased from Mar 10, 1930, to Mar 14, 1930, that I last saw h. alive on Mar 14, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) D. H. Campbell, M. D.

3/17 1930 (Address) 830 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL 117 Zion Ct — Date of Burial Mar 18 1930

20 UNDERTAKER J. L. Brown & Son — ADDRESS 1016 W. Monroe St

very important. See instructions on back of certificate.

R MAR 18 1930 P.M. — W. LAMPSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55179

100-001

E 55179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 704 S. Sharp St. St., 22-31 Ward)

2-FULL NAME Jerome Lovette. (C)

(a) RESIDENCE NO. 704 S. Sharp St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) December 29, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	2	16 18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER James Tucker.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Catherine Lovette.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Catherine Lovette. (C) mother.
(Address) 1006 Stirling St.

15 Filed MAR 18 1930 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronco pneumonia.

unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

3/18/30 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct

DATE OF BURIAL March 18 1930

20 UNDERTAKER S. L. Brown's Son

ADDRESS 1018 N. Monty St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 55180 (2-3447)

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 E 55180

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. (16-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosie Glick

(a) RESIDENCE NO. 1507 Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec-1-1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 067

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bertha Beyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 19 C. HAMPSON JONES, Registrar

MAR 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March-17-1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to March 17, 1930, that I last saw her alive on March 17, 1930, and that death occurred, on the date stated above, at 930 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia, primary

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Rickets, Tetany (?)

(duration) yrs. 1 mos. — da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. O. G. Warren, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale Cem	Mar 18 1930
20 UNDERTAKER M. Jack Lewis	ADDRESS 1439 E Baltimore

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55181

CERTIFICATE OF DEATH

16-29 31

E 55181

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (If N.B. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Lillian Tartar

(a) RESIDENCE NO. 30 S. Amity st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
29	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Tartar

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Cook

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed APR 18 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10, 1930, to March 14, 1930,

that I last saw her alive on March 14, 1930,

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jas Schroeder Jr. M. D.

3-15-30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Mar 18, 1930

20 UNDERTAKER Mrs. Katie R Williams

ADDRESS 3227 Schroeder St

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55182 — 109-E 55182

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH: 1017 East Baltimore St.

CITY OF BALTIMORE: (No. Presbyterian Eye Ear Throat Hospital S. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Jeanette Eigenbrodt.

(Residence in Baltimore: No. 1235 Carroll St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female.	White	

6-DATE OF BIRTH, Sept. 23, 1923. (Month) (Day) (Year)

7-AGE, 6 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, John Eigenbrodt

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Frances Perna.

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Eigenbrodt

(Address) 1235 Carroll St.

15- MAR 18 1930 191... H. C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 16, 1930. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 10 1930, to March 16 1930, that I saw her alive on March 15 1930, and that death occurred, on the date stated above, at 10.25 A.M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Pontine abscess

(Duration) ...yrs. ...mos. ...ds.

(Signed) Joseph Conlan M. D.

191... (Address) 2328 Eastern Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem'y — DATE OF BURIAL, 3-19-..., 1930

20-UNDERTAKER Henry W. Jenkins Son Co. — ADDRESS Orchard & Fulton

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55183

66 E 55183

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 120 E. Hill St. St. 22-6 Ward)

2-FULL NAME Korney Shevchuk.

(a) RESIDENCE NO. 120 E. Hill St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — da. How long in U. S., if of foreign birth? 17 yrs. — mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	88	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address) UNIVERSITY OF MARYLAND

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) February 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

3/8, 1930 (Address) 1011 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAR 18 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

MAR 8 1930

1268 Med

THE MORGAN

Spec.—1-30—M. & T.—250 Bks.

E 55184

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55184

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals ST. 22-30 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Willie McNeal

(a) RESIDENCE NO. 642 Montgomery St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Mar. 15, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	11	16	

8 OCCUPATION OF DECEASED Laborer

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mobile (State or country) Ala.

PARENTS

10 NAME OF FATHER Dave McNeal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ala.

12 MAIDEN NAME OF MOTHER Hager McGrew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala.

14 Informant Records of (Address) Balto. City Hospitals

15 Received MAR 8 1930, 19 C. HAMDEN JONES, M. D., Registrar

THE MONROE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-3-30

17 I HEREBY CERTIFY, That I attended deceased from 2-25-30, 19, to 3-3-30, 19,

that I last saw him alive on 3-3-30, 19,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Facult

(duration) yrs. 3 mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McLean, M. D.

3-4, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

UNDERTAKER Commissioner Health.

ADDRESS MAR 7 1930

PER

Cor.—10-10-29—A Co.—100 Bks.

55185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185

E 55185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1832 N. Washington St. 8-17 Ward)

2-FULL NAME Ida V. Hooper

(a) RESIDENCE NO. 133 Hull st, Brooklyn& N.Y. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Theodore Hooper

6 DATE OF BIRTH (month, day, and year) Jan 19/1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	73	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ------ 07
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Abraham Ricker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. Y.

12 MAIDEN NAME OF MOTHER ----- Zorn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. Y.

14 Informant Ester Swain
(Address) 1832 N Washington St

Filed ..., 19.. Registrar

MAR 18 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull-Prob-Base
Accidently fell down stairs at
1832 N. Washington St Mar 16/30
(duration) ..yrs. ..mos. ..da.

CONTRIBUTORY (Secondary)
(duration) ..yrs. ..mos. ..da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

3/17/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/18/1930

20 UNDERTAKER E. J. Fanning

ADDRESS Inc - 1936 Lafayette Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

154-002

E 55186

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4250 Nicholas Ave ST. 26-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas S. Mitchell

(a) RESIDENCE NO. 4250 Nicholas Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word)
Male	White	Infant

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William V Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eleanor Litz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William V. Mitchell

(Address) 4250 Nicholas Ave

Filed MAR 18 1930 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17-30

17 I HEREBY CERTIFY, That I attended deceased from March 16-, 1930, to March 17-, 1930

that I last saw him alive on March 17-, 1930

and that death occurred, on the date stated above, at 10.30 am

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. Gill Hall, M. D.

March 18. 1930 (Address) 1631 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL March 18th 1930

UNDERTAKER Leo S. Leech

ADDRESS 1733 Patt. Blk Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55187

CERTIFICATE OF DEATH

101-001

E 55187

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 933 Shield St., 17-24 Ward

2-FULL NAME Howard Burrell

(a) RESIDENCE NO. 933 Shield St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race Col

5 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) 1890

7 AGE 40 Years 39 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Florder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Marie Hardy
(Address) 933 Shield

Filed MAR 18 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Coroner, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 3/19 1930

20 UNDERTAKER Thomas E. Nelson

ADDRESS 1303 Pennsylvania Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55188

CERTIFICATE OF DEATH

101-001

E 55188

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 524 W. Preston St., 17-24 Ward)

2-FULL NAME Irvin C. Brown

(a) RESIDENCE NO. 524 W. Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day and year): January 30 1924

7 AGE: Years 5 | Months 7 | Days 13 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country):

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Alice Brown

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country)

14 Informant: Hazel Brown
(Address): 524 W. Preston

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): March 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death by Lobar Pneumonia (duration) ..... yrs. ..... mos. 3 ds.

(Inquest, autopsy or inquiry)

on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular Attendant

(Signed) H. H. Linthicum M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 3/18 1930

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Pleasant St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55189

CERTIFICATE OF DEATH

100-001

E 55189

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3310 Fleet ST., 26-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Young

(a) RESIDENCE NO. 3310 Fleet st ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant

6 DATE OF BIRTH (month, day, and year) March 7 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	2	[redacted]	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William J Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Helen R Pschauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant William J Young (Address) 3310 Fleet st Mother

15 Filed Mch 18 1930 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 17/1930

17 I HEREBY CERTIFY, That I attended deceased from 3/1, 1930, to 3/17, 1930, that I last saw h[redacted] alive on 3/16/30, 19 and that death occurred, on the date stated above, at 4 00 P m.

The CAUSE OF DEATH* was as follows:

1 Bronchitis &

1 Broncho pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) acute Coronac dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Linnell, M. D.

3/17, 1930 (Address) 633 - S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Mch 19 1930

20 UNDERTAKER Lilly & Zeller Sons

ADDRESS 408 E. Wolfe st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55190

99-00 E 55190

CERTIFICATE OF DEATH

REGISTERED NO. 76-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 S. Eaton ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha E. Neugebauer

(a) RESIDENCE NO. 207 S. Eaton ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman Neugebauer

6 DATE OF BIRTH (month, day, and year) June 21 1847

7 AGE Years	Months	Days 23	If LESS than 1 day, hrs. or min.
83	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 1897

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Karl Lange

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Herman Neugebauer
(Address) 207 S. Eaton St

15 Filed MAR 19 1930, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1930, to March 16, 1930, that I last saw h. or alive on March 15, 1930 and that death occurred, on the date stated above, at 6 55 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis (duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stethoscope

(Signed) F. A. Glantz, M. D.

March 19 1930 (Address) 3244 Eastern Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	March 19 1930
20 UNDERTAKER D. Lilly - Guilford Ave	ADDRESS 4030 Monument

Important: Use black ink and write plainly.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55191

99-002

E 55191

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 22-33 Ward)

2-FULL NAME William J. Wheeler.

(a) RESIDENCE NO. 229 E. Montgomery St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, ~~divorced~~ HUSBAND of ~~WIFE~~ Ellen Wheeler.

6 DATE OF BIRTH (month, day, and year) August 20, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor.
(b) General nature of industry, business, or establishment in which employed (or employer) Big Gun Hall.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William A. Wheeler.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Letitia McLaughlin.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant William J. Kelley. (nephew)
(Address) 2850 Kentucky Ave.

15 Filed APR 18 1930 by C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Chronic Bronchitis.
Pulmonary Hemorrhage.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 48 E. Saratoga st. 3/16/30

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinbach, M. D.

3/18. 1930 (Address) 1017 N. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Mar 19 1930

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51 ✓ E 55192

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2027 Maryland Ave ST., 12 WARD)

2—FULL NAME William Thomas Carson

(a) RESIDENCE NO. 2027 Maryland Ave ST., 12 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 5 mos. 19 ds. How long in U. S., if foreign birth? 51 yrs. 5 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Anderson Carson

6 DATE OF BIRTH (month, day, and year) Sept 25 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Building

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER David Carson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Hogg

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland.

14 Informant Mrs Nellie A. Carson (wife)
(Address) 2027 Maryland Ave

15 Filed 1 8 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16-30.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Mar 16, 1930, that I last saw h. liv alive on Mar 16, 1930 and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C. Clarke, M. D.

3, 17, 1930 (Address) Katonka Apt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL 3/19/1930

20 UNDERTAKER Stewart & Memn Co

ADDRESS Balto.

Important. See instructions on back of certificate.

Spec.—1-12-23—MAT—500 Blks.

E 55193

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55193

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH West Balto Cath Hospital ST. 16-68 (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Charles E Thompson

(a) RESIDENCE NO. White Hall Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~Wife~~ of Lena B. Thompson

6 DATE OF BIRTH (month, day, and year) Dec 6. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired RR Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ~~Odd~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mrs. J. Frank Thompson (Address) Parkton, Md

15 Filed MAR 18 1930 . 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 13 1929. to March 18 1930, that I last saw h~~e~~ alive on March 18 1930 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Industrial Infection

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Milton Bortner, M. D.

Mch 20 1930 (Address) White Hall Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodberry Cemetery	Mar 24 1930.
20 UNDERTAKER P. Mackin Low	ADDRESS White Hall Md

CAUSE OF DEATH. See instructions on back of certificates. TION is very important

Spec.—1-30—M. & T.—250 Blks

Dr Campbell 1644 S. Hanover st
South 0059 Apr 21 - 4:12 PM.

E 55194 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

1.-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1730 Light ST 23-32 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2.-FULL NAME Peter A Buckheit

(a) RESIDENCE NO. 1730 Light st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~or WIFE of~~ Elizabeth

6 DATE OF BIRTH (month, day, and year) 2/3/65

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
75	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Peter Buckheit

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Louisa Feltis

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Henry Buckheit (Address) 1730 Light st

15 Filed ....., 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1930 to Mar. 17, 1930, that I last saw him alive on Mar. 17, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. 6 mos 14 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) T. E. K. Campbell M. D.

3/17, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 3/19/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul st

TION is very important. See instructions on reverse of certificate.

R MAR 19 1930 C HAMILTON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

160 ✓

E 55195

CERTIFICATE OF DEATH

E 55195

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Genl Hospital, 11-24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Clinton Cobb.

(a) RESIDENCE NO. Southwell 4, Maryland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 16. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			one	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Roland Harker Cobb

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Bend, Miss.

12 MAIDEN NAME OF MOTHER Cathrine S. M. Thomson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Hospital Record
(Address)

Important. See instructions on back of certificate.

8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1930, to Mar. 11, 1930, that I last saw him alive on Mar. 11, 1930, and that death occurred, on the date stated above, at 3 05 A. m.

The CAUSE OF DEATH* was as follows:

Jaundice & Intussusception.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) John A. Thompson, M. D.

(Address) John Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 3/19 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt St

Spec.—8-16-29—L. F. S.—100 Bks.

V-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55196

CERTIFICATE OF DEATH

12

E 55196

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 Luzerne ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John G. Vinup

(a) RESIDENCE NO. 806 N. Luzerne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Vinup

6 DATE OF BIRTH (month, day, and year) Sept. 20, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing Cutter 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Frederick K. Vinup

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Lena Knapp

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Barbara Vinup

(Address) 806 N. Luzerne St.

15 Filed ..., 19.. Registrar

MAR 18 1930 C. HAMILTON JENNINGS

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 12, 1930, to Mar 17, 1930, that I last saw h[illegible] alive on Mar 17, 1930, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) 1 yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) G. Lawson

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Sig Eg

(Signed) J. C. Elsby, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Mar. 20 1930

20 UNDERTAKER C. H. Miller & Son

ADDRESS 2234 Jefferson St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55197 ✓ 90 E 55197

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 N. Holland Ave WARD) 24-11

2—FULL NAME Mary M. Ries

(a) RESIDENCE NO. 513 N. Holland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Ries

6 DATE OF BIRTH (month, day, and year) March 31/1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	11	17 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John Rodman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant John M. Ries

(Address) 513 N. Holland Ave.

15 Filed 8 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 17/30

17 I HEREBY CERTIFY, That I attended deceased from Mch 11, 1930, to Mch 17, 1930, that I last saw h. w. alive on Mch 17, 1930 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(duration) yrs. mos. 6 da.

CONTRIBUTORY (Secondary) Chronic Endocarditis Infection

Arthritis (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Anna B Lemmon, M. D.

3/19, 1930 (Address) 718 N Fallsway Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loch Raven Cem.

DATE OF BURIAL Mar. 20 1930

20 UNDERTAKER Wm. E. Miller & Son

ADDRESS 2234 Jefferson St.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

Elizabeth

E55198

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 E 55198

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) Baltimore City Hosp. St. 24-31 (WARD)

2-FULL NAME Elizabeth Heilmann

(a) RESIDENCE NO. 904 N. Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) [illegible] 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Heilmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record
(Address)

15 Filed MAR 18 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16-30

17 I HEREBY CERTIFY, That I attended deceased from 3-3, 1930, to 3-16, 1930, that I last saw h[illegible] alive on 3-16, 1930, and that death occurred, on the date stated above, at 12 40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolus - left

(duration) ..... yrs. ..... mos 30 min ds.

CONTRIBUTORY (Secondary) Generalized Arteriosclerosis (duration) Unknown ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Fred M. Dunkerley M. D.

, 19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 3/19 1930

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun & Hollins St

Spec.—1-30—M. & T.—350 Blks

Dr Simp 37 S Stricker St Bx 2468

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55199 — 129 — E 55199

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1947 Harlem Ave ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Christian Starr

(a) RESIDENCE NO. 1947 Harlem Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christianna Starr

6 DATE OF BIRTH (month, day, and year): Oct 16 1859

7 AGE — Years: 70 — Months: 5 — Days: 1 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Catherine Ruther

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): William C Starr 1947 Harlem Ave

MAR 19 1930 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 19 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/22/30, 19..., to 3/17/30, 19..., that I last saw him alive on 3/17/30, 19..., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) ..... yrs. ..... mos. 5 da.

CONTRIBUTORY (Secondary) Arterio Sclerosis Chr. (duration) ..... yrs. 7 mos. ..... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) J. M. Starr, M. D.

3/18/30 (Address) 3755 Shirley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: 3/20 19 30

20 UNDERTAKER: J. M. Cook — ADDRESS: 1217 E Fayette St

TION is very important. See instructions on back

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55200

CERTIFICATE OF DEATH

× 74 001

E 55200

24-33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at the

City of Baltimore: (No. South Baltimore General Hospital St., Ward)

2-FULL NAME Frederick F. Lauenstein.

(a) RESIDENCE NO. Pasadena, A. A. Co. Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower.

5a If [illegible], widowed or [illegible] HUSBAND of (or) [illegible] Katherine Lauenstein

6 DATE OF BIRTH (month, day, and year) July 21, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	65	7	24 36	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brick layer.
(b) General nature of industry, business, or establishment in which employed (or employer) Oil
(c) Name of employer

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER Henry Lauenstein.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Karl Lauenstein. (son)
(Address) Pasadena, A. A. Co. Md.

Filed MAR 19 1930 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted? Pasadena, A. A. Co. Md
If not at place of death? 3/17/30
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

3/18. 1930 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	3/20/1930
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul st

IMPORTANT: Please write plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. Use ink and write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55201 ✓ E 55201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3314 Liberty St. (If death occurred in a hospital or institution, give its NAME instead of street and number.) WARD

2—FULL NAME Elanora Coleman

(a) RESIDENCE NO. 3314 Liberty St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Coleman

6 DATE OF BIRTH (month, day, and year) July 29-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
73 74	7	19		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Croyton

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S Unknown

12 MAIDEN NAME OF MOTHER Jane Lowin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gettysburg - Pa.

14 Informant Edith Shaffer (Address) Daughter same

15 HAMPSON JONES, M. D. Registrar

MAR 19 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March-16-1930

17 I HEREBY CERTIFY, That I attended deceased from July, 1929, to March 16, 1930, that I last saw her alive on March 14, 1930 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chr-nephritis-Myocarditis Arterio-sclerosis Cerebral hoemorrhage-in July & left hemiplegia (duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Cronpneu-both feet (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) Fernando Enis Nichols M. D.

, 19 (Address) 9 East Chas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 3-20 1930

UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55202 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55202

90

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. B-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Siurvilas SURVILAS

(a) RESIDENCE NO. 116 Albemarle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	Singl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1878 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Litvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Litvania

14 Informant John Chlkavckas

(Address) 116 Albermale Street

15 Filed MAR 8 1930 Registrar C. HAWSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930 to March 18, 1930

that I last saw h[illegible] alive on March 18, 1930

and that death occurred, on the date stated above, at 2 35 p.m.

The CAUSE OF DEATH* was as follows:

Myocardeal insufficency,
Pulmonary edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H Varney, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL March 20. 1930

20 UNDERTAKER M. D. John Grebliauckas J. G.

ADDRESS 423 S Paca St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55203 Md Penitentiary 92E 55203

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH ~~Daniel Hayden~~ 10-15

City of Baltimore: (No. 900 a 904 Gaud St. Ward)

2-FULL NAME Daniel Hayden

(a) RESIDENCE NO. 900 a 904 Gaud St., Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]
(c) Name of employer [illegible]

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Wm Hayden

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Ruth S Ervin

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Billy Arundel
(Address) 2029 McCulloh St

15 Filed [illegible] 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 192 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Sudden (duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death? [illegible]

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? _____

(Signed) H. L. Riley, M. D.

Mch 18 1930 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	3-19 1930
20 UNDERTAKER Byron Wright 1218 N Eldersley St	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

R 1 9 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT, CITY OF BALTIMORE

89

E 55204

CERTIFICATE OF DEATH

E 55204

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 Wheeler Ave. ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Philip Alexander Denison

(a) RESIDENCE NO. 5206 Springlake Way ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. — mos. — da. How long in U. S., if foreign birth? 43 yrs. — mos. — da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Bauer

6 DATE OF BIRTH (month, day, and year) --------

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer and Mdse.

(b) General nature of industry, business, or establishment in which employed (or employer) Manager

(c) Name of employer O'Neill & Company

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Not obtainable

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Alfred B. Denison

(Address) 5206 Springlake Way

15 Filed APR 19 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from October 15th, 1929, to March 17th, 1930, that I last saw him alive on March 3, 1930, and that death occurred, on the date stated above, at 3 p.m. The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. 2 mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) unknown yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Therapeutic effect amyl nitrite

(Signed) Maurice C Pmedlys, M. D.

, 19 (Address) 24 E. Lager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 3/19 1930

20 UNDERTAKER Landrey & Weaver and Son

ADDRESS 805 N. Calvert

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55205

CERTIFICATE OF DEATH

74-001

E 55205

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2108 Pennsylvania Ave. WARD 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy Bartas

(a) RESIDENCE NO. 2108 Pennsylvania Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Bartas

6 DATE OF BIRTH (month, day, and year) June 10th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68.	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuanian

PARENTS

10 NAME OF FATHER Geo. Lubare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuanian

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuanian.

14 Informant Mr John A. Bartas

(Address) 2108 Pennsylvania Ave

15 Filed 19 Registrar

HAMPSON JONES, M. D.

APR 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 14 1930 to March 17 1930,

that I last saw her alive on March 17 1930

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Spilmeyer, M. D.

3/18 1930 (Address) 682 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem.

DATE OF BURIAL 3/21 1930.

20 UNDERTAKER John F. Cowan & Son

ADDRESS

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55206

CERTIFICATE OF DEATH

74001

REGISTERED NO. E 55206

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 930 Burgundy St. 21-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles W. LeBow

(a) RESIDENCE NO. 930 Burgundy ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lottie LeBow

6 DATE OF BIRTH (month, day, and year) Jan 9th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Elias E LeBow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Susanna Kathen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Lottie LeBow

(Address) 930 Burgundy St.

15 Filed MAR 9 1930 S. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/16/30, to 3/17/30, that I last saw h— alive on 6/17/30 and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 20 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Dorsey M. D.

(Address) 1 W Mt Vernon Pl

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 3/20/ 1930

20 UNDERTAKER Robt Cowen & Son

ADDRESS Greenmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 55207

1—PLACE OF DEATH
CITY OF BALTIMORE. (No. South Baltimore Gen. Hospital ST., WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Viola Wendel

(a) RESIDENCE NO. 1737 Patapsco ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 4 mos. 22 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
BUSBAND of (or) WIFE of George Wendel.

6 DATE OF BIRTH (month, day, and year) Oct. 20 - 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS
10 NAME OF FATHER Wm. R. Squires
11 BIRTHPLACE OF FATHER (city or town) Q. Q. Co (State or country) Md.
12 MAIDEN NAME OF MOTHER Mary Seales
13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant George Wendel. (Address) 1737 Patapsco

15 [illegible] 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-17-30

17 I HEREBY CERTIFY, That I attended deceased from 2-13-30, 19..., to 3-17, 1930, that I last saw h.er alive on 3-17, 1930 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs

(Signed) Joseph B. Laukaitis, M. D.
(Address) South Balto Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem — DATE OF BURIAL 3/21 1930

20 UNDERTAKER J. F. McCauley — ADDRESS 120 N. Fremont

Spec.—1-10-21—M&T—1500 Bks.

E 55208

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 V E 55208

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 935 Park Avenue 11-24 WARD)

2-FULL NAME Luke Henry

(a) RESIDENCE NO. 935 Park Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Henry

6 DATE OF BIRTH (month, day, and year) Aug 15 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	7	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer P.R.R. Co.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Nathan Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Charlotte Roy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Henry

(Address) 935 Park Ave

15 Filed MAR 19 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from 1/9/ 19 29 to March 12 19 30, that I last saw him alive on March 12, 19 30, and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 3 mos 6 ds.

CONTRIBUTORY (Secondary) Hard work

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. C. Hirst, M. D.

3/18, 1930 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 3/19/30 19

20 UNDERTAKER Samuel Steinberg — ADDRESS 5784 Liddle St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55209

CERTIFICATE OF DEATH

91-002

E 55209

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 E. North Ave 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna C. Zimmerman

(a) RESIDENCE NO. 524 E. North Ave 9th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Female~~	Wh.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Philip Zimmerman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Johannah Seifert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Edw. Zimmerman
(Address) 524 E. North Ave

Filed MAR 19 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/17/30

17 I HEREBY CERTIFY, That I attended deceased from February 18th, 1930, to March 17th, 1930

that I last saw her alive on March 17th, 1930

and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation 1 7 Days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Howard E. Woodyear M. D.

3/18/1930 (Address) 530 E. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Mar 20 1930

20 UNDERTAKER Fred A. Kraemer

ADDRESS 703 E

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55210

CERTIFICATE OF DEATH.

90 E 55210

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 27-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... St. ..... Ward)

2-FULL NAME Charles A Deets

(a) RESIDENCE No. 2506 Crest Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Sophia L. Deets

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73.	3.	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None~~ Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Deets

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of Baltimore City Hospitals (Address)

MAR 19 1930

17 Filed ... C. HAMPSON JONES, M. D. Registrar

Rec'd ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18-30

17 I HEREBY CERTIFY, That I attended deceased from 2-9-28, 19..., to 3-18-30, 19..., that I last saw him alive on 3-18-30, 19..., and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

3-18, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden.

DATE OF BURIAL 3/20/1930

20 UNDERTAKER Walter Davis

ADDRESS 3307 Raines St.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 55211

E 55211

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1751 N. Gay St. ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Barner

(a) RESIDENCE NO. 1751 N. Gay St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas D. Barner

6 DATE OF BIRTH (month, day, and year) Dec. 7/1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Conrad Roemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. L. Long

(Address) 1751 N. Gay St.

15 Filed MAR 16 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18/30

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1929, to Mar 18, 1930, that I last saw h.. alive on Mar 18/, 1930, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sternum

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) Carcinoma of Pancreas

(duration) yrs. 7 mos. 18 da.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John W Burnett, M. D.

3-9, 1930 (Address) 1710 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Mar 22/30

UNDERTAKER P. Philip Sterwig

ADDRESS 2016 Eutaw St

TION is very important See instructions on back of certificate

Spec.—8-16-29—L. F. S.—100 Bks.

23748 2
E 55212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH X 146 ✓ REGISTERED NO. E 55212

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgia Elliott —

(a) RESIDENCE NO. Sycamore Ave — ST., Sparrow WARD DT —
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND ~~of~~ (or) WIFE of Thomas —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 19 — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Da —

9 BIRTHPLACE (city or town) (State or country): Da —

PARENTS

10 NAME OF FATHER Geny Brayer

11 BIRTHPLACE OF FATHER (city or town) Da — (State or country)

12 MAIDEN NAME OF MOTHER Henrietta Grimm

13 BIRTHPLACE OF MOTHER (city or town) Da — (State or country)

14 Informant Records — (Address) JOHNS HOPKINS HOSPITAL

15 MAR 19 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar-17-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1930, to Mar-17, 1930, that I last saw her alive on Mar-17, 1930, and that death occurred, on the date stated above, at 5-45 a. m.

The CAUSE OF DEATH* was as follows:

Puerperal Peritonitis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Essex, Md.

Did an operation precede death? No Date of

Was there an autopsy? Yes March 17, 1930

What test confirmed diagnosis? autopsy

(Signed) H H Snyder, M. D.

Mar 17, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hobson Bd. Mem.

DATE OF BURIAL: 21 1930

20 UNDERTAKER: Chas. N. Johnson 446 N.

ADDRESS Caroline St.

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 55213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74001 E 55213

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1046 Valley St., 10-14 Ward)

2-FULL NAME Mary C. Reynolds

(a) RESIDENCE NO. 1046 Valley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12/1869

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	61	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Punlic School
(c) Name of employer Teacher

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Thomas Reynolds

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Gilcrest

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. Burroughs (sister)
(Address) 1046 Valley St

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

MAR 19 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 16/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Bowen, M. D.

3/18/30 (Address) 500 E. Mort: Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar 20 1930

UNDERTAKER Rita Medefield

ADDRESS 9 E Lexington

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55214 90 ✓ E 55214

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1602 Lamont Ave. ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena E. Krickbaum

(a) RESIDENCE NO. 1602 Lamont Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Krickbaum

6 DATE OF BIRTH (month, day, and year) March 15, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	-	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Louis Louis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. John Taylor

(Address) 1602 Lamont Ave.

15 Filed MAR 19 1930 16 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-8, 1930, to 3-18, 1930 that I last saw her alive on 3/18, 1930 and that death occurred, on the date stated above, at 11.45 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

3/18, 1930 (Address) 1500 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Mar. 21 1930

20 UNDERTAKER Joseph L Cook

ADDRESS 1003 West Baltimore St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 55215

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 E 55215

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2439 N Charles St. 7-50 WARD)

2-FULL NAME Kate Ward

(a) RESIDENCE NO. 22 East 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 64 or 65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Phil. Pa.

PARENTS

10 NAME OF FATHER Dr Rufus Ward

11 BIRTHPLACE OF FATHER (city or town) Rock Creek (State or country) Montgomery Co - Md

12 MAIDEN NAME OF MOTHER Priest (Susan)

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs B F. Diehl (Address) 22 E 24th St Balto.

15 Date received MAR 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 17 12-15 , 1930 , to Mch 12 4.30 P m. 1930 , that I last saw her alive on March 17 , 1930 , and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Dr. Coroner J. Mossberg

Cerebral attack 4 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Not known.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? The usual test heart

(Signed) M. L. Degraw M. D.

, 19 (Address) 2439 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL March 19 1930

20 UNDERTAKER W M Rountree

ADDRESS 2208 N Mth

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT NATURE OF DISEASE TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

E 55216

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55216

1-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) N31 Jefferson ST. 9-9 (WARD)

2-FULL NAME Rosalee Hankins

(a) RESIDENCE NO. N31 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lee Hankins

6 DATE OF BIRTH (month, day, and year) 12 26 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39 yrs	39	2	2/2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Isaac Hankins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Redd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah Hankins

(Address) N 91 Jefferson St

MAR 19 1930 HARRY M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 18/3/30

17 I HEREBY CERTIFY, That I attended deceased from 11/3/, 19 30 to 18/3/, 19 30

that I last saw h. alive on 17/3/, 19 30

and that death occurred, on the date stated above, at 8 9. m.

The CAUSE OF DEATH was as follows:

Ty Fever

about five weeks

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) about 1 wk. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dallas Ind.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) L. Mansfield Boyle M. D.

19 3 30 (Address) 832 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery

DATE OF BURIAL March 19 1930

20 UNDERTAKER Edward Boyce

ADDRESS 163 Orleans

TION is very important. See instructions on back of certificate.

Spec.—1-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55217

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 211 S. Fulton Ave (St.) 9-28 (Ward)

REGISTERED NO. 55217

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Mary Seubolt

(a) RESIDENCE NO. 211 S. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Michael Seubolt

6 DATE OF BIRTH (month, day, and year): July 16 1846

7 AGE: Years 83 Months 9 Days 1 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Bauserein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Mollie Seubolt

(Address) 211 S. Fulton Ave

Filed 1930 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 17 1930

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to March 17, 1930,

that I last saw her alive on March 17, 1930,

and that death occurred, on the date stated above, at 5.20 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

3/18, 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 3/20 1930

UNDERTAKER: Geo. C. Jules

ADDRESS: Fulton & Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55218

CERTIFICATE OF DEATH

101-001 E 55218

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 617 Georgia St. 17-25 Ward)

2-FULL NAME Robt Green.

(a) RESIDENCE NO. 617 George St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male / Female ✓

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): Aug 26-1929

7 AGE: Years ... Months 6 Days 20 22 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town): Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER: Stuart Green

11 BIRTHPLACE OF FATHER (city or town): Pa.
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Fitzhugh

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country) Md

14 Informant: Mary Green
(Address) 617 George

15 Filed ..... 19... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.

March 18 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: Mar 19 1930

20 UNDERTAKER: Mr Kate (?) Williams — ADDRESS 3221 Schroeder St

MAR 19 1930

NOTE—Undertaker should be certain that every question is answered. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

60-002

55219

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55219

CERTIFICATE OF DEATH

1—PLACE OF DEATH Good Shepherd Home & Hospital

CITY OF BALTIMORE: (No. 1512 Gilmore St. 16-23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel Gatlin

(a) RESIDENCE NO. 909 N. Carrollton Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Carriger

6 DATE OF BIRTH (month, day, and year) Mar 7, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 07

(b) General nature of industry, business, or establishment in whirh employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Morristown, (State or country) Tennessee

PARENTS

10 NAME OF FATHER Jones Carriger

11 BIRTHPLACE OF FATHER (city or town) Morristown (State or country) Tenn.

12 MAIDEN NAME OF MOTHER Mildred Smith

13 BIRTHPLACE OF MOTHER (city or town) Gladesprings (State or country) Va

14 Informant Joseph Gatlin

(Address) 909 N Carrollton Ave

MAR 19 1930

Filed ..... HARRY JONES, M.

By ..... Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/16/1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1930, to Mar 16, 1930

that I last saw h[illegible] alive on 3/16-30, 19 .....

and that death occurred, on the date stated above, at 6:20 PM.

The CAUSE OF DEATH was as follows:*

Mitral Regurgitation

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Goitre, Operation & Bronchitis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of 1929

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W R Hopkins, M. D.

19 (Address) 1512 Gilmore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Mar. 19, 1930

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 322 N Schroeder St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55220 E 55220

CERTIFICATE OF DEATH

REGISTERED NO. 74-00

1—PLACE OF DEATH Union Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1129 ST., WARD)

2—FULL NAME Miss Ray Goldman

(a) RESIDENCE NO. 2441 Eutaw Ave (If non-resident give city or town and State) Altamont Hotel

(Usual place of abode)

Length of residence in city or town where death occurred yrs. How long in U. S., if foreign birth? yrs. mos. ds.

Lifetime

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) About 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hester Fraley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Records

(Address)

15 Filed APR 19 1930 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to March 17, 1930, that I last saw h e alive on March 17, 1930 and that death occurred, on the date stated above, at 12-17 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. T. Shuckerford, M. D.

March 17, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 3/20/1930

UNDERTAKER David Sondheim

ADDRESS 1520 W. Mt. Royal Ave

Important. See instructions on back of certificate

Spec.—1-12-23—M&T—500 Blks.

55221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1002

12 27 E 55221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4709 Pennington Ave. WARD 27) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Fedo

(a) RESIDENCE NO. 4709 Pennington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~: James Fedo

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: James Fedo

(Address): 4709 Pennington Ave

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1930, to Mar. 16, 1930.

that I last saw her alive on Mar. 16, 1930

and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

Cirhossis of liver

(duration) yrs. 2 mos 16 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. H. Campbell M. D.

3/18, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cross Brooklyn

DATE OF BURIAL: Mar 20 1930

UNDERTAKER: John M. Feeder

ADDRESS: Chester

TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

51 ✓ E 55222

E 55222

CERTIFICATE OF DEATH

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Butler

(a) RESIDENCE NO. 4015 Dolphin ST., WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 13 mos. da. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1916 Sept

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	13	6		

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particulsr kind of work Schoolchild

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Butler

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Florence Butler
(Address) 1915 Duncan St

15 Filed _____, 19 _____ C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-17-30

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 17, 1930, that I last saw him alive on March 17, 1930 and that death occurred, on the date stated above, at 2 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever

(duration) ___ yrs. ___ mos. 22 da.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ___ yrs. ___ mos. 10 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ___

Was there an autopsy? ___

What test confirmed diagnosis? Clinical & St Clair

(Signed) Carroll M. St Clair, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leland Cemetery	3/20/ 1930
20 UNDERTAKER	ADDRESS
Edward H. Bailey	1421 Jefferson St

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55223

CERTIFICATE OF DEATH.

38 E 55223

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals 2231

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Albert Garland

(a) RESIDENCE NO. 15 Hudgis 1153 Hughes St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10 NAME OF FATHER Albert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oklahoma

12 MAIDEN NAME OF MOTHER Willie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oklahoma

14 Informant Records of (Address) Balto. City Hosp.

15 Filed MAR 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-14-30

17 I HEREBY CERTIFY, That I attended deceased from 12-26-29, 19..., to 3-14-30, 19..., that I last saw him alive on 3-14-30, 19..., and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

over

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

over (duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin W. McCleary M. D.

3-15, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

UNDERTAKER

ADDRESS

MAR 19 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55224

CERTIFICATE OF DEATH.

31 E 55224

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. ..... ST. 5-4 WARD)

2-FULL NAME Julius Svensson

(a) RESIDENCE NO. 632 S. Broadway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Unknown yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37 36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown 087

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed 4168 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to March 14, 1930, that I last saw him alive on March 14, 1930, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M.D.

3-15, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER [signature] Commissioner Health.

ADDRESS MAR 19 1930

TION IS VERY IMPORTANT. See instructions on back. REGISTERED BY HARRISON JONES, M.D.

Spec.—1-30—M. & T.—250 Bks.

E 55225

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55225

75-001

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST. 4-6 WARD)

2-FULL NAME Charles Smith

(a) RESIDENCE NO. 114 Market Place ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
59-70	?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Records of
(Address) Balto. City Hospitals UN

15 Filed MAR 19 1930, 19 HAMPSON JONES, M. D. Registrar
4169

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-16-30

17

I HEREBY CERTIFY, That I attended deceased from 11-4-25, 19..., to 3-16-30, 19...,

that I last saw him alive on 3-16-30, 19...,

and that death occurred, on the date stated above, at 12:45 P. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Hemiplegia, ? (old)

(duration) ..... yrs. 9 mos. ..... ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

3/17, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS MAR 19 1930

Spec.—1-30—M. & T.—250 Blks.

E 55226

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 55226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4705 Fairhaven Ave. ST., 25-77 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arnold Edwin Wolfe

(a) RESIDENCE NO. 4705 Fairhaven Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant

6 DATE OF BIRTH (month, day, and year) April 15-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Morris Wolfe

11 BIRTHPLACE OF FATHER (city or town) Lonaconing (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Berkow

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Morris Wolfe

(Address) 4705 Fairhaven Ave

15 FILED MAR 9 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1930, to Mar 19, 1930, that I last saw him alive on Mar 18, 1930, and that death occurred, on the date stated above, at 8-30 9 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) A. V. Bucheuch, M. D.

3/19, 1930 (Address) 37 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 3/19 1930

20 UNDERTAKER Jack Levin — ADDRESS 1409 E Balto St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55227

CERTIFICATE OF DEATH

122-002

E 55227

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Mcdeen ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie G. Wills

(a) RESIDENCE NO. 1424 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas L. Wills

6 DATE OF BIRTH (month, day, and year) July 13, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Haid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Krocke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas L Wills

(Address) 1424 N Eden St

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1929, to March 18, 1930, that I last saw her alive on March 17th, 1930 and that death occurred, on the date stated above, at 9.20 A. m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) E. McClure, M. D.

3/18/, 1930 (Address) 1114 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 21st 1930
20 UNDERTAKER Henry Aberle & Sons, Inc.	ADDRESS 1301 E Eager St

Important. See instructions on back of certificate.

Spec. 8-16-29—5 E S 100 Bks.

E 55228

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55228

CERTIFICATE OF DEATH

235030

N. Surg

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 (WARD)

2—FULL NAME John Poke

(a) RESIDENCE NO. Rock Oak - Hardy Co. W. Va. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	17	-	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W. Virginia

PARENTS

10 NAME OF FATHER Geo. F. Poke

11 BIRTHPLACE OF FATHER (city or town) (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Louise L. Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 19 1930 19 C. JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19-30

17 I HEREBY CERTIFY, That I attended deceased from 3-17-, 19 30, to 3-19-, 19 30, that I last saw him alive on 3-19-, 19 30 and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Brain tumor of brain stem — Glioma (malignant)

(duration) yrs. 8 mos. da.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 3-18-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Fred W Keil, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Oak W Va

DATE OF BURIAL 3/19/30

20 UNDERTAKER Joseph Ahrens

ADDRESS 22 N Bway

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55229

CERTIFICATE OF DEATH.

1000 001 55229

REGISTERED NO.

1-PLACE OF DEATH Howard Park

CITY OF BALTIMORE: (No.) 5002 Norwood Ave (Ward) 28-64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Henry Fenge

(a) RESIDENCE. NO. 5002 Norwood Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Artist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Fenge

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Mulder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Rosa B Fenge 5002 Norwood Ave

Filed MAR 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1930

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1930, to March 18, 1930, that I last saw him alive on March 18, 1930, and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Bronco pneumonia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/18, 1930 (Address) 720 N Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 20
20 UNDERTAKER	ADDRESS
George J Smith	Hollins 157

CAUSE OF DEATH in plain terms, so that a ... TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55230

CERTIFICATE OF DEATH.

47 E 55230

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 322 S. Payson St. (ST.) 20-69 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Eyer

(a) RESIDENCE NO. 322 S. Payson St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Louis Ph. Eyer

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Edward Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Edellman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Louis Ph. Eyer
(Address) 322 S. Payson St.

15 Filed MAR 19 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from December 25, 1929 to March 17th. 1930.

that I last saw her alive on March 17th. 1930,

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Auto-intoxication

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. Neuslaeber M. D.

3/18 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Mar. 21 1930

20 UNDERTAKER George L. Schwab ADDRESS 101 Fulk Ave.

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 55231

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 55231

CERTIFICATE OF DEATH

REGISTERED NO. 20

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 Park Avenue ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Lough Dallam

(a) RESIDENCE NO. 1529 Park Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 17 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	6 4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 008

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago, Illinois

PARENTS

10 NAME OF FATHER Joseph Worthington Dallam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Octavia L. Lough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co. Md

14 Informant Mrs. Eureka Dallam

(Address) 1529 Park Ave. Balto

15 Filed APR 1 1930 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3.18.30

17 I HEREBY CERTIFY, That I attended deceased from March 15 1930 to 19

that I last saw h alive on March 18th 1930

and that death occurred, on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:

Cirrhosis Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

March 19 1930 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	March 20 1930
20 UNDERTAKER	ADDRESS
Henry Meakins & Sons Co	Oxford Fairfield Md

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55232

CERTIFICATE OF DEATH

46 E 55232

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 313 N. Mount ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Carter

(a) RESIDENCE NO. 313 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 26, 1889

7 AGE: Years 40 Months 8 Days 24 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Washington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Jos Carter

(Address): 313 N. Mount

15 Filed ..... 19..... Registrar

C. HAMPSON JONES, M. D.

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1930 to March 18 1930, that I last saw h alive on March 17 1930 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulm Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Norment, M. D.

March 19 1930 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — DATE OF BURIAL: March 23 1930

20 UNDERTAKER: Joseph A Bruch — ADDRESS: 409 N Mount St

Important. See instructions on back of certificate.

Spec. 1-30—M. & T.—250 Blks.

E 55233 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55233

31

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 N. Kenwood Ave St. 7-10 WARD)

2-FULL NAME Albert F. Havranek

(a) RESIDENCE NO. 636 N. Kenwood Ave St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Havranek

6 DATE OF BIRTH (month, day, and year) Oct. 14-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer F. W. Dornan Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Havranek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Mary Havlik

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Anna Havranek
(Address) 636 N. Kenwood Ave.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930 to March 18, 1930

that I last saw h... alive on March 17, 1930

and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Aortic Endocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin

(Signed) J. Julius Levy, M. D.

(Address) 636 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer cemetery

DATE OF BURIAL Mch. 21 1930

20 UNDERTAKER George M. Zirkler

ADDRESS 1737 E. Eager St.

FORM N very important

Spec.—1-30—M. & T.—250 Blks.

E 55234

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55234

CERTIFICATE OF DEATH.

47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 923 S. Curley ST. 11 WARD)

2-FULL NAME Lyda B. Sutherland

(a) RESIDENCE NO. 923 S. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Sutherland

6 DATE OF BIRTH (month, day, and year) Dec 6- 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant Raymond Sutherland (Address) 923 S. Curley St.

15 Filed 1930 Per C. HAMPSON JONES, M. D. Registrar

R 197930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16- 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 30, to Mar. 15, 30,

that I last saw h alive on Mar. 15, 30,

and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma right breast.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. Joseph Tenley, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL March 20, 30

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager

TION IS very important

Cor.—10-20-29—A Co.—100 Bks.

E 55235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170

E 55235

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

Pronounced dead at 15-55 (Date)

City of Baltimore: (No.) St. Joseph Hospital St.

2-FULL NAME Gustave James Wagner

(a) RESIDENCE NO. 5258 Park Hts Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct. 31 - 1909

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	20	4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Manager 23rd
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery store
(c) Name of employer J. N. Brooks Co

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Gustave Wagner

11 BIRTHPLACE OF FATHER (city or town) Brooklyn
(State or country) N. Y.

12 MAIDEN NAME OF MOTHER Emily L. Powell

13 BIRTHPLACE OF MOTHER (city or town) Martinsburg
(State or country) W. Va

14 Informant (Address) Gustave Wagner 5258 Park Hts Ave

15 Filed ..... 19 C. HAMPSON JONES M. D. Registrar

R 1 9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot wound thru temple
(Suicide)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1602 Gorsuch Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Wallis, M. D.

3/19/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Martinsburg W. Va — DATE OF BURIAL Mar 23 1930

20 UNDERTAKER Wm. J. Tickner Son — ADDRESS W. Va

THE CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55236

CERTIFICATE OF DEATH

167-E 001 55236

1-PLACE OF DEATH

City of Baltimore: (No. 111 E. 25th Street St. 17-50 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Bell Cromwell.

(a) RESIDENCE NO. 111 E. 25th Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Donald McDade Cromwell

6 DATE OF BIRTH (month, day, and year) Dec 20th 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	32	2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Victor de Murguondo

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Donald Cromwell
(Address) 111 E. 25th St

15 Filed ..... 19 ..... Registrar

R 19 1930 C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 7th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Asphyxia (Illuminating Gas.) (duration) Sudden

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Smith, M. D.
Coroner.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 10 30
20 UNDERTAKER	ADDRESS
Wm J. Tuckner & Sons	N. Gay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55937

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-801

E 55937

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818-N-Calvert ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nora Simpson Crichton

(a) RESIDENCE NO. 1818-N-Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 79 yrs. 9 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James E. Crichton

6 DATE OF BIRTH (month, day, and year): June-16-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) Louisville

(State or country) Kentucky

PARENTS

10 NAME OF FATHER: John S. Kennedy

11 BIRTHPLACE OF FATHER (city or town) Belfast

(State or country) Ireland

12 MAIDEN NAME OF MOTHER: Ethal Ragland

13 BIRTHPLACE OF MOTHER (city or town) Louisville

(State or country) Kentucky

14 Informant: Mrs. Sarah B. Littlejohn

(Address) 1818-N-Calvert St

15 Filed 1930 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19-30

17 I HEREBY CERTIFY, That I attended deceased from 3-4, 1930, to 3-18, 1930, that I last saw h[illegible] alive on 3-18, 1930 and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

MYOCARDIAL INSUFFIC.

(duration) 10 + yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) CEREBRAL HEMORRHAGE

(duration) — yrs. — mos. 2 ds.

18 Where was disease cantracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] L. Dorsey, M. D.

, 19 (Address) 1129 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Petersburg Va.	3/19/1930
20 UNDERTAKER: Stewart & Co	ADDRESS: Balto.

Important. See instructions on back of Certificate

Spec.—1-10 21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55238

CERTIFICATE OF DEATH.

E 55238

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St. Joseph Hospital ST., 4-17 WARD)

2-FULL NAME Charles Emrold

(a) RESIDENCE NO. Pennsylvania Ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mildred Emrold

6 DATE OF BIRTH (month, day, and year) Jan 19 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer & Dairyman

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel L. Emrold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Wanderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Samuel L. Emrold

(Address) 5501 Hillsdale

15 1 9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/30 19

17 I HEREBY CERTIFY, That I attended deceased from 3/14/30, 19 to 3/18/30, 19,

that I last saw him alive on 3/18/30, 19,

and that death occurred, on the date sisted above, at 2 00 m.

The CAUSE OF DEATH* was as follows:

gangrenous appendicitis and peritonitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) cardiac degeneration

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3/14/30

Was there an autopsy? Partial

What test confirmed diagnosis? Gualtair

(Signed) M. Anderson M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Mar 20 1930

20 UNDERTAKER George Schilling & Sons

ADDRESS 1111 Monument St

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Kreis ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55239 49 E 55239

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3047 Frisby ST. 15-65 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth C. Kreis

(a) RESIDENCE NO. 4121 Norfolk Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 11 mos. 23 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Kreis

6 DATE OF BIRTH (month, day, and year) Mar. 24, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Gebhart H. Bahlman

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER --------

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Geo. H. Dumler

(Address) 1735 Ellamont Avenue

15 Filed G. HAMPSON JONES, M. D. Registrar

MAR 19 1930 By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17-1930

17 I HEREBY CERTIFY, That I attended deceased from March 14- 1930, to March 17- 1930, that I last saw h er alive on March 17- 1930 and that death occurred, on the date stated above, at 11-46 P. m.

The CAUSE OF DEATH* was as follows:

Hyper-nephroma -

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis & Edema Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscopy.

(Signed) E. Gill Hall, M. D.

March 17 1930 (Address) 1631 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/20 1930

ADDRESS

UNDERTAKER Henry U. Mears & Son 805 N. Calvert

Important. See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Blks.

E 55240

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55240

CERTIFICATE OF DEATH

160

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2403 Georgetown Rd. (ST.) 6 (Norfolk Park WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George H. Long

(a) RESIDENCE NO. 2403 Georgetown Rd. ST. Morrell Pk WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER William Long

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Meier

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mr. William Long,
(Address) 2403 Georgetown Rd.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 18, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1930, to Mar 18, 1930.

that I last saw him alive on Mar 18, 1930

and that death occurred, on the date stated above, at 1 00 P. m.

The CAUSE OF DEATH* was as follows:

Starvation

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Augustine P. Vondenhuevel M.D.

, 19 (Address) 580 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 3/20/1930

20 UNDERTAKER: Harry N. Pritzke ADDRESS: 4101 Edmondson Ave.

HAMPSON JONES, M

R 1 1930 ... Registrar

important. See instructions on back of certificate.

Cor.—10-10-28—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55241

E 55241

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St., 4-28 Ward)

2-FULL NAME Wm Tseng

(a) RESIDENCE NO. 120 S. Streeter St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Catherine Tseng

6 DATE OF BIRTH (month, day, and year) Dec 8-1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	66	3	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Adam Tseng

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs Catherine F Tseng
(Address)

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Carcinoma of Oesophagus

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Donnell Brosius M. D.

3/18, 1930 (Address) 3601 3 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 3/21/1930

20 UNDERTAKER Harry H Wilke

ADDRESS 4101 Edmondson Ave

This Schedule is in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECORD C. HAMPSON JONES, M. D.

Spec.—1-10 21—M&T—1500 Bks.

E 55242

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55242

CERTIFICATE OF DEATH.

1-001

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Avenues ST. 19-28 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ira Bryant

(a) RESIDENCE NO. 1523 W Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Madeline And Bryant

6 DATE OF BIRTH (month, day, and year) Aug. 4 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.Y.

PARENTS

10 NAME OF FATHER Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (wife) Madelyne Bryant
(Address) 1523 W. Lombard St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

R 1 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-11 1930, to 3-18 1930, that I last saw him alive on 3-18 1930, and that death occurred, on the date stated above, at 4 50 p m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. 1/2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Widal

(Signed) Paul Cohen, M. D.

3/18 1930 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 3/22/30

20 UNDERTAKER Harry J. Dietzel

ADDRESS 410 Edmondson av

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55243

CERTIFICATE OF DEATH

49 E 55243

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1832 N Washington ST. 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjamin H. Swain

(a) RESIDENCE NO. 1832 N Washington St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4. COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 25. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk, Retired

(b) General nature of industry, business, or establishment in which employed (or employer) R R

(c) Name of employer P. R. R

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Capt Abram R Swain

11 BIRTHPLACE OF FATHER (city or town) N. Y.
(State or country)

12 MAIDEN NAME OF MOTHER Christiana Dora

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mary E Swain
(Address) 1832 N Washington St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to Mch 19, 1930
that I last saw h alive on Mch 18, 1930
and that death occurred, on the date stated above, at 3:35 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Right kidney.

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

3/19. 1930 (Address) 1823 N. Haselton.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL 3/21 1930

20 UNDERTAKER Wm. Cook

ADDRESS 1210 St Paul St

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

Davidov 2035 O'Donnell St

E 55244 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 55244

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1114 W. Fayette St. 18 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A Bredekamp

(a) RESIDENCE NO. 1114 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Herman Bredekamp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Fleischmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Annie Bredekamp 1114 W Fayette St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1929 to March 17, 1930, that I last saw him alive on March 11, 1930, and that death occurred, on the date stated above, at 10 9 m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos 5 da.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. J. Davidov, M. D.

19 (Address) 2035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 3/20 1930

20 UNDERTAKER Wm Cook — ADDRESS 1212 E Pratt St

TION is very important. See instructions on reverse side.

Spec.—1-30—M. & T.—250 Blks

Dr Bishop

E 55245

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55245

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 416 Beninghous Rd ST. 21-28 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elnora Cecelia Stricker

(a) RESIDENCE NO. 416 Beninghous Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Stricker

6 DATE OF BIRTH (month, day, and year): Jan 27, 1887

7 AGE — Years: 43 | Months: 1 | Days: 21 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (City or town) (State or country): Ellicott City Md.

PARENTS

10 NAME OF FATHER: John Horton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Emma Kusack

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Wm Stricker 416 Beninghous Rd

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930, to March 18, 1930, that I last saw h[illegible] alive on March 18, 1930, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Ch Myocarditis, Ac St Nephritis

Acute - Oedema

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. N. Bishop, M. D.

Mar 19 1930 (Address) 501 Sheridan Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Govans

DATE OF BURIAL: 3/20 1930

20 UNDERTAKER: [illegible]

ADDRESS: 1217 E Baltimore St

TION is very important. See instructions on reverse side.

MAR 19 1930 PLANNING DEPARTMENT

Spec.—1-30—M. & T.—250 Blks

Dr Shannon 700 Fulton ✓

E 55246

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55246

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3206 (St.) Brighton (Ward) 16-67

2-FULL NAME John Daniels

(a) RESIDENCE NO. 3206 Brighton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Daniels

6 DATE OF BIRTH (month, day, and year) Dec 28, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wallace Luykendall

(Address) 3206 Brighton St

15 Filed MAR 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929, to Mch 17, 1930, that I last saw h.. alive on Mch 17, 1930, and that death occurred, on the date stated above, at 9 15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. 6 mos 6 ds.

CONTRIBUTORY (Secondary) Coma

(duration) 6 yrs. 6 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon, M. D.

, 19 (Address) 700 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 3/21 1930

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E Pratt St

TION is very important. See instructions for

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55247 ✓

E 55247

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 90-69 (WARD)

2-FULL NAME 2501 Lauretta Ave

(a) RESIDENCE NO. Mr Lee Walker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Walker

6 DATE OF BIRTH (month, day, and year) July 27 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Welder

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Grace Walker

(Address) 2501 Lauretta ave.

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-16 .1930. to 3-19 .1930.

that I last saw him alive on 3-19 .1930.

and that death occurred, on the date stated above, at 9 00 a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia complicated by vegetative endocarditis with cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem

DATE OF BURIAL 3/22 1930

20 UNDERTAKER J. W. Cook

ADDRESS 2117 E Lord St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

R 3-1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55248

CERTIFICATE OF DEATH

47

E 55248

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Linden Avenue ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Nelson Fink

(a) RESIDENCE NO. 1428 Linden Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Fink

6 DATE OF BIRTH (month, day, and year) ——— 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Near Frederick

(State or country) Maryland

PARENTS

10 NAME OF FATHER ——— Nelson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER ——— Foutz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Wm. M. Conkling

(Address) 1428 Linden Avenue

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1929, to Mch 19, 1930, that I last saw h. alive on Mch 19, 1930 and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Carcinoma breast 1918 Operation 1918 (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry H. McCurdy, M. D.

2-19-1930 (Address) 57 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/21 1930

20 UNDERTAKER Henry U. Meaker and Son

ADDRESS 805 N. Calvert

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

235-039
E 55249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 84 E 55249

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mozelle Wagaman

(a) RESIDENCE NO. Lynnoch - ST., Iowa WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21 - 1925

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4 ½	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Iowa

PARENTS

10 NAME OF FATHER Willard Wagaman

11 BIRTHPLACE OF FATHER (city or town) Iowa (State or country)

12 MAIDEN NAME OF MOTHER Bertha Lashbrook

13 BIRTHPLACE OF MOTHER (city or town) Iowa (State or country)

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

15 Date MAY 19 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19-30

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1930, to Mar - 19, 1930, that I last saw her alive on Mar - 19, 1930 and that death occurred, on the date stated above, at 2 50 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor glioma

1 yr (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 15-III-30

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) E. H Compton, M. D.

, 19 (Address) Johns Hopkins Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newton Iowa

DATE OF BURIAL May 19 1930

20 UNDERTAKER Geo M. Smith & Son

ADDRESS 811 N Wolfe

Important. See instructions on back of this certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55250 160 E 55250

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 Hanover St. 27-34 Ward)

2-FULL NAME Reta Finger

(a) RESIDENCE NO. 530 Hanover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 17/30

7 AGE	Years	Months	Days 2 / 1	If LESS than 1 day, 2 hrs. or 2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER Edmund Finger.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Illinois

12 MAIDEN NAME OF MOTHER Mariedress.

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.
(State or country)

14 Informant Edmund Finger
530 Hanover St.

Filed ..... 1930 C. HARRISON JONES, M. D., Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19 1930.

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1930, to March 19, 1930, that I last saw h[illegible] alive on March 19, 1930, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Congenital Debility
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. K. L. Campbell M. D.

3/19, 1930 (Address) 164 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral County — DATE OF BURIAL 3/20 1930

20 UNDERTAKER Fred A. Kronenberg — ADDRESS 703 Hanover St

SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 55251

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55251

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1134 Hanover St. 23-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry T. Burkhardt

(a) Residence No. 1134 Hanover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE White

5-Single, Married, Widowed, or Divorced (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 16 1872

7-AGE 57 yrs. 9 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frederick Burkhardt

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Frederick Md.

12-MAIDEN NAME OF MOTHER, Katherine Neymans

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Washington D.C.

14- (Informant) John H. Robinson

(Address) 1134 Hanover St.

15- Filed MAR 20 1930, 192 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 17th 1930

17- I HEREBY CERTIFY, That I attended deceased from Feb. 28th, 1930, to March 17th, 1930.

that I last saw him alive on March 17th, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tabes Dorsalis (Blood Wassermann negative Spinal Wassermann not made)

(Duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings.

(Signed) [illegible], M. D.

3/19, 1930 (Address) 1124-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Cathedral Cemetery DATE OF BURIAL, Mar. 20, 1930

20-UNDERTAKER, Margaret E. Flynn ADDRESS 1124-26 Hanover St.

instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55252

CERTIFICATE OF DEATH.

100-001 E 55252

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 241-N- Schroder St. 15-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gregiana Carroll

(a) RESIDENCE NO. 241-N- Schroder St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Samuel Orbut

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John T. Smith

(Address) 244 Schroder

15 Filed [illegible] 19 C. HAMILTON JONES, M. D. Registrar

R 201930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18- 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-12- 1930 to 3-18 1930

that I last saw h[illegible] alive on 3-17- 1930

and that death occurred, on the date stated above, at 12:10 p m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio-pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. J. Jackson M. D.

3/18 1930 (Address) 600 Darlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 3-21 1930

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Hull

TION is very important See instructions on back of certificate

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55253 ✓

E 55253

N - Surg.

CERTIFICATE OF DEATH X 84

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bernard Munson

(a) RESIDENCE NO. Rockville Centre ST., ida WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Long Island How long in U. S. if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-30-21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Bernard Munson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Julia Bremner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19-30

17 I HEREBY CERTIFY, That I attended deceased from 3-18-, 1930, to 3-19-, 1930, that I last saw him alive on 3-19-, 1930 and that death occurred, on the date stated above, at 5-52 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

Uncertain (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-19-30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) C. H. Frazier, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville Cemetery L. I. N.Y.

20 UNDERTAKER W. J. Fechner & Sons

DATE OF BURIAL Mar 20 1930

ADDRESS North Penna

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55254 — 100-001 — E 55254

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospls. — REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore St. 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ghikas Liakoutses

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer O&D

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) Balto City Hosp

15 Filed MAR 29 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18-30

17 I HEREBY CERTIFY, That I attended deceased from 3-18-, 1930, to 3-18, 1930, that I last saw h[illegible] alive on 3-18-, 1930 and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Myocardial Changes Coronary Sclerosis.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes autopsy

What test confirmed diagnosis? Microscopical findings

(Signed) Nathan Goldman, M. D.

3/19, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Mar 20, 1930
UNDERTAKER Thanowetho Lon	ADDRESS 3615 Gunter Ave

Important: See instructions on reverse side.

Spec.—1-10-21—M&T—1500 Bks.

E 55255

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 55255

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 589 Alford ST. 17-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Ringgold

(a) RESIDENCE NO. 589 Alford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8. 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Florence Ringgold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Florence Ringgold

(Address) 589 Alford St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17. 1930

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1930 to March 17, 1930.

that I last saw him alive on March 14, 1930,

and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) A. Lee Clem, M. D.

3/18, 1930 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	March 20, 1930
20 UNDERTAKER Mrs. F. C. Elliott	ADDRESS 1725 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

70 ✓ E 55256

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. President Hospital ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Brown

(a) RESIDENCE NO. 151 Enon Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 1, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	5	17	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Brown

11 BIRTHPLACE OF FATHER (city or town) Columbia Ga
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Rosa ~~Johnson~~ Ironman

13 BIRTHPLACE OF MOTHER (city or town) Fluv. Cond
(State or country) Virginia

14 Informant Joseph D. Brown
(Address) 157 Enon alley

15 Filed ..... 19 ..... Registrar

MAR 20 1930 BALTIMORE, MD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18-30

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to March 18, 1930, that I last saw him alive on March 18, 1930 and that death occurred, on the date stated above, at 1 05 a. m.

The CAUSE OF DEATH* was as follows:

Acute Encephalitis (Primary)

(duration) ....yrs. 10 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Carroll M. McClain, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Mar. 20 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1726 Ashland Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001

E 55257

CERTIFICATE OF DEATH

E 55257

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen. Hosp. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Floyd Hall

(a) RESIDENCE NO. 1429 Argyle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geneva Hall

6 DATE OF BIRTH (month, day, and year) January 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odr

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Bell, Md.

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Maggie Brown

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Geneva Hall

(Address) 1429 Argyle Ave

15 Filed MAR 20 1930 S. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 19..., to March 14, 19 30,

that I last saw h[im] alive on March 14, 19 30

and that death occurred, on the date stated above, at 5-30 a m.

The CAUSE OF DEATH* was as follows:

Vascular Diseases

Syphilitic

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? On Head

What test confirmed diagnosis? Spinal fluid test

(Signed) E. A. Pilsinger, M. D.

, 19 (Address) 1213 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Mar. 23 1930

UNDERTAKER Mrs. E. A. Elliott

ADDRESS 1223 East Lanvale

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55258 — 129 ✓ — E 55258

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Aisquith ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sr. M. Adelphia Drescher

(a) RESIDENCE NO. Notre Dame Convent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 17 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer Sisters of Notre Dame

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter Drescher

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Aloysia Wingefeld

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sisters of Notre Dame
(Address) 901 Aisquith Street

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

MAR 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to March 18, 1930, that I last saw h. m. alive on March 18, 1930 and that death occurred, on the date stated above, at 5.45 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Nephritis
Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual ones

(Signed) F. J. Kirby, M. D.

3/19, 1930 (Address) 110 E. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Cliff	March 20 1930
20 UNDERTAKER Frank A. Fink	ADDRESS 910 N. Gay St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55259 ✓ E 55259

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto. City Hospital St., 1923 Ward)

2-FULL NAME William Ferris

(a) RESIDENCE NO. 1132 Penna Ave Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce
(b) General nature of industry, business, or establishment in which employed (or employer) Dealer
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C. Fargo, Nubert Clark

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Irene Clark

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Mary Ferris
(Address) 1132 Penna Ave.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

2 8 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Ex

(Signed) C. C. Hades, M. D.

19 (Address) 1430 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	3/20/1930
20 UNDERTAKER	ADDRESS
Chas. F. Handley	578 W. Biddle

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55260

CERTIFICATE OF DEATH

44 ✓

E 55260

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 708 S. Bethel ST. 3-4 (WARD)

2—FULL NAME Adam Dzieciatko

(a) RESIDENCE NO. 708 S. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of ~~[illegible]~~ Maryanna Dzieciatko

6 DATE OF BIRTH (month, day and year) Dec 15/1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52.	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER John Dzieciatko

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. Dzieciatko
(Address) 708 S. Bethel st

15 Filed C. HAMILTON JONES, M. D.
Registrar

MAR 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19/30

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to March 18, 1930, that I last saw him alive on March 18, 1930, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory + Physical

(Signed) M. Hayes, M. D.

, 19 (Address) 2430 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL 3/22/30

20 UNDERTAKER George A. Weber

ADDRESS 706 S. Ann st

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55261

55261

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 20-37 (WARD)

2-FULL NAME Mr Joseph Feinour

(a) RESIDENCE NO. 1906 N. Fairmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary B. (nee Fitzer)

6 DATE OF BIRTH (month, day, and year) Mch 16, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.... min.
	42		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer 045

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Charles W. Feinour

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary K. Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mrs Mary Feinour 1906 N. Fairmount Ave

15 Filed MAR 20 1930 C. HAMPSON JONES, M. D. Registrar

PAT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-15 1930, to 3-18 1930, that I last saw h[illegible] alive on 3-18 1930, and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Rheumatic Carditis

Auricular Fibrillation

Cardiac Decompensation

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl Cohen M. D.

3/18 1930 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 3/21/1930

20 UNDERTAKER: Harry H. Nitzke

ADDRESS: 4101 Edmondson Ave.

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Each statement of cause of death TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

185

CERTIFICATE OF DEATH

E 55262 | REGISTERED NO. E 55262

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp St 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Anna Waters

(a) RESIDENCE NO. 804 N Fulton ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 17 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bel Air (State or country) Md.

PARENTS

10 NAME OF FATHER William Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda Dunbar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Union Memorial Hospital (Address) Records

15 Filed MAR 20 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 18. 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 8, 1930, to Mar 18, 1930, that I last saw h[illegible] alive on Mar. 17, 1930 and that death occurred, on the date stated above, at 1:20 a.m.

The CAUSE OF DEATH* was as follows:

Traumatic Fracture of left femur

C/K. Coroner J. J. Morrissey

(duration) 6 yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia Complicating and Pulmonary Tuberculosis (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Xray.

(Signed) Jesse L. Fifer, M. D.

Mar 18. 1930 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Brick Meeting House Md DATE OF BURIAL Mar 20 1930

20 UNDERTAKER A Taube ADDRESS 1013 N. Fulton Ave

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55263 111-001 E 55263

CERTIFICATE OF DEATH.

REGISTERED NO. 5462

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3402 Edgewood Rd. (ST.) (WARD) Govanstown

2-FULL NAME Mrs. Anne McGrain

(a) RESIDENCE No. 3402 Edgewood Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late John McGrain

6 DATE OF BIRTH (month, day, and year): July 6 - 1860

7 AGE: Years 69 Months 8 Days 12 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Wheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): John McGrain 3402 Edgewood Road

15 Filed MAR 20 1930 C. HAMPSON JONES, M.D.

By:

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 11, 1930. to March 18, 1930. that I last saw her alive on 3-18-1930. and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

(Penetrating) Ulcer Stomach about 1 yr (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis Last Few days (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Allerwith Correll M.D.

3/19. 1930 (Address) 3705 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery DATE OF BURIAL 3-21-1930

UNDERTAKER: H. C. Brauning & Son, Potter Space 21 ADDRESS 1136 E. A. Brauning, Successor.

CAUSE OF DEATH in plain terms, so that it may be properly Classified. EXACT information is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55264

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55264

14-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1rr S. Exeter ST. 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Miller

(a) RESIDENCE NO. 1rr S. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	widower

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pensioned Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Gen. Electric Co of

(c) Name of employer Balto. Md.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Mrs. Louis Miller

(Address) 1rr S. Exeter St.

APR 20 1930

Filed ....., 19 C. [illegible] JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from June, 1925, to March 16, 1930

that I last saw him alive on March 16, 1930

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

① Cerebral Apoplexy —

② Chr. Bronchial Asthma —

③ Chr. Nephritis ?

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy / sudden

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. F. Swinglo, M. D.

3/18, 1930 (Address) 109 E. Pratt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel

DATE OF BURIAL March 20 1930

20 UNDERTAKER Mendel & Lippert

ADDRESS 300 Eden

Spec.—1-12 23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55265

CERTIFICATE OF DEATH.

101 E 55265

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3120 Belmont Ave., St. 16-67 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kernan

(a) RESIDENCE NO. 3120 Belmont Ave., St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 22, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Edward A. Kernan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Edna M. Meehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Edward A Kernan
(Address) 3120 Belmont Ave.

15 Filed APR 20 1930 19 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 12th., 1930, to March 18th., 1930, that I last saw her alive on March 18th., 1930, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. A. Kernan, M. D.

3/19 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Mar. 21st 1930

20 UNDERTAKER Charles F. Bill.

ADDRESS 3109 Frederick Ave

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55266

CERTIFICATE OF DEATH

43 ✓

E 55266

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1941 W. Baltimore St. (WARD) 28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Dittmar

(a) RESIDENCE NO. 1941 W. Baltimore St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 ~~Single, Married, Widowed,~~ or ~~Divorced, (write the word)~~: widower

If married, widowed, or divorced.
HUSBAND of (or) WIFE of: Caroline Dittmar

6 DATE OF BIRTH (month, day, and year): April 29 1867

7 AGE: Years 62 Months 10 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Baker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter Dittmar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Philipine Seaman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Edwina K. Ferguson

(Address) 1941 W. Baltimore St.

15 Filed MAR 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 18 1930

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1930, to March 18, 1930,

that I last saw h[illegible] alive on March 18, 1930

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left
inferior maxillary bone

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. E. Jones, M. D.

3/19, 1930 (Address) 720 W. Lord Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	March 21 1930
20 UNDERTAKER	ADDRESS
J. Fossardens Son	2173 Pen

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55267 100-001 E 55267

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2821 Washington Blvd ST. 25-7 WARD)

2-FULL NAME George Leo King

(a) RESIDENCE NO. 2821 Washington Blvd ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 28. 1929.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leo. James. King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Johanna Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Leo. J. King

(Address) 2821 Washington Blvd.

15 Filed MAR 20 1930 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to March 19, 1930, that I last saw him alive on March 18, 1930, and that death occurred, on the date stated above, at 3.20 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm A. Strauss, M. D.

3/19, 1930 (Address) 1901 Griffis Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar. 21 1930

20 UNDERTAKER John A. Moran — ADDRESS 3000 E. Monument St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of CONDITION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55268

CERTIFICATE OF DEATH.

74 E 55268

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 N. Montford St. 16 WARD)

2-FULL NAME Sarah V. Loftus

(a) RESIDENCE NO. 1723 N. Montford ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced, (or) WIFE of Michael Loftus

6 DATE OF BIRTH (month, day, and year) Feb 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER William O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Sarah Mallany

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sarah V. Loftus

(Address) 1723 N. Montford ave.

15 Filed MAR 20 1930 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to March 18, 1930, that I last saw her alive on March 16, 1930, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pessagno, M. D.

3, 19, 1930 (Address) 514 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Mar 21 1930

UNDERTAKER John L. Moran

ADDRESS 3000 E. Balto.

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55269

CERTIFICATE OF DEATH.

24 001
24 E 55269
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 S. Broadway ST., 24 WARD)

2-FULL NAME Emma A. Bressler

(a) RESIDENCE NO. 125 S. Broadway ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Dr. Frank E. Bressler

6 DATE OF BIRTH (month, day, and year) Oct. 17th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Dr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER J. Jno. Tiburing

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Tickel

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Dr. Frank E. Bressler
(Address) 125 S. Broadway

15 Filed APR 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1930 to March 17, 1930, that I last saw her alive on March 17, 1930, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteri-Sclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical signs

(Signed) [illegible], M. D.

3/18/30 (Address) 408 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 20th 1930
UNDERTAKER	ADDRESS
Lilly & Guier Sts.	403 S. Wolfe St.

HOW IS very important. See instructions on back of Certificate

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

55270

REGISTERED NO. E 55270

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Eastern ave ST. 22 WARD)

2—FULL NAME Marie Bamberger

(a) RESIDENCE NO. 2016 Eastern ave ST. 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced, (write the word)~~
Female	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John. Bamberger

6 DATE OF BIRTH (month, day, and year) Jan 26-1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Nicolas Everd.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Zeblein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John. Bamberger (Address) 1407 Bank st. Hanlak

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1930, to Mar. 18, 1930, that I last saw h a alive on Mar 14, 1930 and that death occurred, on the date stated above, at 12 15 ~~AM~~ PM m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia with Mitral Stenosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R Morley Young, M. D.

Mar 19, 1930 (Address) 727 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Mch. 21st 1930

20 UNDERTAKER Zeibert Inc.

ADDRESS 1038 Walbert

Mar 20 1930 C. HAMPSON Registrar

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55271

CERTIFICATE OF DEATH.

11-001

11 E 55271

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gilman Apartments 31st & Calvert ST. 12-50 Ward

2-FULL NAME Ruth Haslup

(a) RESIDENCE NO. 31st & Calvert Sts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John S. M. Haslup

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Rider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Mary Rider Haslup

(Address) Gilman Apartments

15 FILED MAR 20 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to March 19, 1930, that I last saw her alive on March 18, 1930, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos 11 da.

CONTRIBUTORY (Secondary) Pneumonia (Influenzal)

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George M. Little M. D.

3/19, 1930 (Address) 2435 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Mar. 21 1930

UNDERTAKER: John O. Mitchell & Sons, 1900 Eutaw Pl.

ADDRESS

Mahlon B. Mitchell

HOW IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55272 — 129 E 55272

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Md. General Hospital ST., 13-20 WARD)

2—FULL NAME Joseph W. Peterson

(a) RESIDENCE NO. 2004 Mt. Royal Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11 1874

7 AGE — Years: 55 | Months: 8 | Days: 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman & dealer

(b) General nature of industry, business, or establishment in which employed (or employer): Wholesale Hardware 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto - Md.

PARENTS

10 NAME OF FATHER: George P. Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co. Md.

12 MAIDEN NAME OF MOTHER: Margaret Dare

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co. Md.

14 Informant: Mr. Geo. P. Peterson

(Address): 2004 Mt. Royal Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19/30

17. I HEREBY CERTIFY, That I attended deceased from 3/19 1930, to 3/19 1930,

that I last saw h[illegible] alive on 3/19 1930

and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis - hypertension

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Jas. A. Humpstone M. D.

3/19/30 (Address) 1 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Mch 21 1930

20 UNDERTAKER: Wm. D. Mitchell & Sons

ADDRESS: Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55273

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55273

CERTIFICATE OF DEATH

REGISTERED NO. 78

1—PLACE OF DEATH 136 W. Lanvale St.

CITY OF BALTIMORE: (No. 136 W. Lanvale ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Daves

(a) RESIDENCE NO. 136 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1. 1900

7 AGE: Years 29 | Months 10 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dallo Md

PARENTS

10 NAME OF FATHER: Chas C. Daves

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rita

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John C. Daves (Address) 136 W. Lanvale St.

15 Filed 19 Register

C. HAMPTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1930, to March 19, 1930.

that I last saw h Am alive on March 19, 1930

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 23 yrs. mos. ds.

CONTRIBUTORY (Secondary) Circulatory Shock, dehydration

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Lawson Hopkins, M. D.

Mar 19, 1930 (Address) 1014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md

DATE OF BURIAL: March 20 1930

20 UNDERTAKER: John D. Weber & Sons

ADDRESS: Place

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55274

CERTIFICATE OF DEATH

5 1 E 55274

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 N.Chapel St., ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Janda

(a) RESIDENCE NO. 834 N.Chapel St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anton Janda

6 DATE OF BIRTH (month, day, and year) Dec.8,1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Vaclav Florijanek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Barbara Vodak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Anna Sykora

(Address) 834 N.Chapel St.,

15 Filed MAR 20 1930 19 HAMILTON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March, 19/30

17 I HEREBY CERTIFY, That I attended deceased from March 10 19 30 to March 19 19 30

that I last saw h Sr alive on March 19 19 30

and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wilbur M. Sauer, M. D.

Mch 19 1930 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Mar.22 19 30

20 UNDERTAKER Frank Cvach & Son 1906

ADDRESS Ashland Ave.

Important. See instructions on back of certificate

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55275 44 E 55275

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 Ashland Av ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Kitak

(a) RESIDENCE NO. 1914 Ashland Av ST., _____ WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Kitak

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor 8d

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Kitak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Marie Klima

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Anna Kitak

(Address) 1914 Ashland Av

15 Filed _____, 19__ _____ Registrar

Par _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 19/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, to March 19 1930, that I last saw him alive on March 19, 1930 and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? X Ray

(Signed) Louis Braun, M. D.

, 19 (Address) 2 Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL March 22 1930

20 UNDERTAKER Frank Brack & Son — ADDRESS 1906 Ashland Av

Important. See instructions on back of certificate.

Spec—12-23-21—E.R.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 55276

CERTIFICATE OF DEATH.

Registered No. .....

E 55276

1-PLACE OF DEATH

City of BALTIMORE: (No. 213 N. Poppleton St., 46-76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Elizabeth Johnson

(a) Residence No. 213 N. Poppleton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 3-2-30

7-AGE yrs. mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of Industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9-BIRTHPLACE (city or town) Baltimore, Md.
(State or Country)

PARENTS

10-NAME OF FATHER, Herman Johnson

11-BIRTHPLACE OF FATHER (city or town) Northumberland County
(State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Mary Alice Chase

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country),

14- (Informant) Mary Johnson (Mother)
(Address) 213 N. Poppleton St.

15- MAR 20 1930 19— C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Mar. 17, 1930

17- I HEREBY CERTIFY, That I attended deceased from Mar. 2 19 30 to Mar. 17 19 30, that I last saw h.. alive on Mar. 17 19 30, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Louis Haas Lass M. D.

3/18, 1930 (Address) Mun. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Zion Cemetery	Mar. 20, 1930
20-UNDERTAKER. Mrs. Katie R. Williams	ADDRESS 322 N. Schroeder St.

Filed Mar 20 1930 Per PHA

instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55277 ✓ 129 E 55277

E 55277

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH 1505 Mulberry St

CITY OF BALTIMORE: (No. ..... ST. 19-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Clara Adams

(a) RESIDENCE NO. 1505 Mulberry ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	ed	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Maryland

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Smith

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Mrs. Smith

(Address) 1505 Mulberry St.

15 Filed ..... 19 ..... Registrar

MAR 20 1930 HAMILTON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-17-30

17 I HEREBY CERTIFY, That I attended deceased from 3-16-30, 19..., to 3-17-30, 19...,

that I last saw h... alive on 3-16-30, 19...

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

(Cardio-Vascular-Renal Disease)

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. W. B. Butler, M. D.

19 (Address) 425 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Mar. 20 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3221 Schroeder St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55278

CERTIFICATE OF DEATH

162 E 55278

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 915 W. Fayette St. 18-26 Ward)

2-FULL NAME Annie May Pedrew

(a) RESIDENCE NO. 915 W. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 12-1930

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
			7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jacob Pedrew

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Jessie Lewis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Mrs J. Pedrew
(Address) 915 W. Fayette St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Selby M. D.

3/20, 1930 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	March 20 1930
20 UNDERTAKER Miss Katie R. Williams	ADDRESS 3227 Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

234735

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55279

CERTIFICATE OF DEATH

X 101-001

E 55279

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Bihl

(a) RESIDENCE NO. Harrisburg Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia

6 DATE OF BIRTH (month, day, and year) Oct-11-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Victor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Emma McCall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed [illegible] 19[illegible] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20-1930

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1930, to March 20, 1930, that I last saw h. m. alive on March 20, 1930 and that death occurred, on the date stated above, at 5 50 A m.

The CAUSE OF DEATH* was as follows:

Pyorrhoea, rt.

[illegible]

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (lobar)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 14, 1930.

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) L. H. Smith, M. D.

3/20, 1930 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisburg Pa.

DATE OF BURIAL 3-20 1930

20 UNDERTAKER David Sandheim

ADDRESS 18 W Mt Royal Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

55280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 55280

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospt St. 5-8 (Ward)

2-FULL NAME Annie Brown

(a) RESIDENCE NO. 527 East St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Brown

6 DATE OF BIRTH (month, day, and year) Unknown. 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Thomas Mealey
(Address) 527 East St.

15 Filed ..., 19.. C. HARRISON JONES, M. D. Registrar

R 20 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows: Acc Fall - (Coro)

1 (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Wade, M. D.

19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cemetery — DATE OF BURIAL Mar. 19, 1930

20 UNDERTAKER Wm. R. Ga. Elliott — ADDRESS 1725 Ashland Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55281 — CERTIFICATE OF DEATH — 101-001 — E 55281

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy Smith

(a) RESIDENCE NO. 222 Vincent ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Salisbury (State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Nancy Smith (Address) 222 N Vincent St

15 Filed MAR 20 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to March 14, 1930, that I last saw h[illegible] alive on March 14, 1930, and that death occurred, on the date stated above, at 1 56 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL MAR 20 1930

20 UNDERTAKER Commissioner Health.

Address

Important. See instructions on back before writing.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55282

CERTIFICATE OF DEATH

66 E 55282

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1000 Low St. St., 5-8 Ward)

2-FULL NAME Cerrie E. Ferguson. (C)

(a) RESIDENCE NO. 1000 Low St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ---- How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Colored	Widow.

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~X~~ (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	30	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(h) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Georgia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. C.D.
(Address)

15 Filed MAR 20 1930 19 RMH, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 6, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

3/18. 1930 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55283

CERTIFICATE OF DEATH

181 - E 55283

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St., 3-5 Ward)

2-FULL NAME Charles Miller.

(a) RESIDENCE NO. 30 S. Albemarle St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Adam Urben.
(Address) 30 S. Albemarle St.

15 Filed MAR 20 1930 H. MAUSON JONES, M. D. Registrar

Per RUK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 9, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Stuminating gas poisoning.
Broncho Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 30 S. Albemarle St. March 1, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

3/18, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

THE MORGUE

MAR 20 1930

1172

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 55284

HEALTH DEPARTMENT—CITY OF BALTIMORE

90E 55284

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1884 S. Charles St. St., 9-13 Ward)

2-FULL NAME Albert Noll.

(a) RESIDENCE NO. 880 N. Washington St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Lena Noll.

6 DATE OF BIRTH (month, day, and year) April 28, 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	54	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Glass polisher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Lena Noll. (wife)
(Address) 880 N. Washington St.

15 Filed AUG 20 1930 C. HARRY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.
Acute dilatation of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

8/19. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	March 1930
20 UNDERTAKER Geo M. Frost Co Inc	ADDRESS Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.P.R.S.—400 Blks.

E 55285

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55285

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1607 Harmden Court) (Ward) 100-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Evans

(a) Residence No. 1607 Harmden Court Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE White

5-If married, widowed, or divorced, HUSBAND of (or) WIFE of Milton Evans

5a-Single, Married, Widowed, Divorced (Write one)

6-DATE OF BIRTH (month, day and year) July 5 1867

7-AGE 67 yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER Albert Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country) New York

12-MAIDEN NAME OF MOTHER Mary E. Royce

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto. Md.

14- (Informant) Emma Evans

(Address) 3022 Road Towson

15- Filed 1938 C. HAMPSON MORRIS, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar. 18 1930

17- I HEREBY CERTIFY, That I attended deceased from Mar 13 1930 to Mar 18 1930

that I last saw h... alive on Mar 18 1930

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH was as follows:

1 Broncho pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchitis

(Duration) yrs. mos. 10 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. [illegible] M. D.

3/20 1930 (Address) 1 E Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	March 21, 1930
20-UNDERTAKER	ADDRESS
Margaret S. Flynn	417 Light St.

instructions on back of certificates.

AR 20 1938

Spec.—1-30—M. & T.—250 Blks.

E 55286

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55286

CERTIFICATE OF DEATH.

REGISTERED NO. 100-001

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 19-27 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Morningstar

(a) RESIDENCE NO. 1426 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1843 ~~Unknown~~

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87 ?	2	12	

8 OCCUPATION OF DECEASED None Unknown

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER John Morningstar ~~Unknown~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 3-20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18-30

17 I HEREBY CERTIFY, That I attended deceased from 2-10-30, 19..., to 3-18-30, 19...,

that I last saw him alive on 3-18-30, 19...,

and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ...yrs. ...mos 2 da.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ...yrs. ...mos. ...da.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McLean, M. D.

3-19, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stone Chapel Cemetery

DATE OF BURIAL Mar. 21 1930

20 UNDERTAKER Robt. B. Cook

ADDRESS 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Blks

Collington & Tuxedo

E 55287

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 55287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 800 N. Mt. Belmont St. (Ward) 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Roland Hersey

(a) RESIDENCE NO. 800 N. Mt. Belmont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm Hersey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Emma Bender

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Bertha Bender

(Address) 2721 Aisquith St.

15 Filed MAR 20 1930 19 C. HAMPSON SMITH, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 - 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15 1930 to March 20 1930

that I last saw him alive on March 20 1930

and that death occurred, on the date stated above, at 2 45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Joseph Pokorny, M. D.

19 (Address) 2200 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pa

DATE OF BURIAL 3/21 1930

UNDERTAKER D. Brennan Cook

ADDRESS 127 St Paul

TION is very important. See instructions on

Spec.—1-30—M. & T.—250 Blks

Dr Ruzecka 1st Port Pk Cor

E 55288 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

90 E 55288

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 134 N Castle ST., 6-9 (WARD)

2-FULL NAME Augusta Crist

(a) RESIDENCE NO. 134 N Castle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Crist

6 DATE OF BIRTH (month, day, and year) Jan 9 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jessie Martens (Address) 134 N Castle St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18 1930

17

I HEREBY CERTIFY, That I attended deceased from March 19 30 to March 19 30

that I last saw h.. alive on March 19 30

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Rheumatic

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility Cardiac Dilatation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Mr Dodson

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) E. E. Hodges M. D.

3-19-30 (Address) 800 N Patterson Pk

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 3/21 1930

20 UNDERTAKER W. Cook

ADDRESS 1317 E Fayette St

TION is very important. See instructions on back of this certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55289

CERTIFICATE OF DEATH.

129 E 55289

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 E. North Ave. ST. 13-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph L. Dunn

(a) RESIDENCE NO. 730 E. North Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Kehoe Dunn

6 DATE OF BIRTH (month, day, and year) July 1st 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

063

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER William Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary J. Latta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Annie K. Dunn

(Address) 730 E. North Ave.

15 Filed 3-20-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2 1930 to March 18 1930.

that I last saw h alive on March 18 1930.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Endocarditis with Senile Dropsy

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Ch Lues-hyphritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No ✓

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3/19 1930 (Address) 5. Club Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL Mar. 22 1930

20 UNDERTAKER Chas. F. Grace How 1800 N. Royal Ave

ADDRESS

CAUSE OF DEATH to be plainly written. No abbreviation may be employed. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55290

90 E 55290

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2828 E. Chase ST. 8-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James E. Smart

(a) RESIDENCE NO. 2828 E. Chase ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Smart

6 DATE OF BIRTH (month, day, and year) June 4 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER James Smart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Jana Killmont

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Elizabeth M. Smart

(Address) 2828 E. Chase St

15 Filed MAR 26 1930, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18. 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 19 30 to March 18, 19 30

that I last saw h. alive on March 15, 19 30

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cataract Both eyes

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) B V Kelly, M. D.

, 19 (Address) 1009 Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Mar 21 19 30

20 UNDERTAKER William G. Schaefer

ADDRESS 816 Monument

Important: See instructions on back

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55291 X-188-203 E 55291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals St. 26-27 Ward)

2-FULL NAME William A. Burkhardt

(a) RESIDENCE NO. Bradshaw Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 2 1909

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	21	1	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

PARENTS

10 NAME OF FATHER George B. Burkhardt

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary L. Gerke

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant George B. Burkhardt
(Address) Bradshaw Md

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Truck he was driving ran into ditch throwing him out.

ACC, dental (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Bradshaw Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Shaum, M. D.

3/19/30 (Address) 2939 14 - Elders

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Mar 22 30
20 UNDERTAKER	ADDRESS
Frederick Lassahn	Fullerton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 20 1930

Spec.—1-30—M. & T.—250 Bks.

E 55292

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55292

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6304 Belair ST., 27-42 WARD)

2-FULL NAME John G. Koenig Sr

(a) RESIDENCE NO. 6304 Belair ST., WARD

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Koenig

6 DATE OF BIRTH (month, day, and year) March 25, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bavaria (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John J. Koenig (Address) 6304 Belair Road

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 30

I HEREBY CERTIFY, That I attended deceased from March, 19 30, to March 18, 19 30, that I last saw him alive on March 18, 19 30, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

7 (duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. C. Gladden, M. D.

19 (Address) 1436 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Mar. 21 1930

20 UNDERTAKER Frederick Lansdale

ADDRESS Fullerton

THON IS very important. See instructions on reverse side.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002 ✓ E 55293

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2403 Barclay ST. 12-5D (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Inaguet Briggs

(a) RESIDENCE NO. 2403 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. m. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 20-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
76	11	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Frank Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Luella Riely

(Address) 2403 Baselay St

15 Filed MAR 20 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/19/30

17 I HEREBY CERTIFY, That I attended deceased from 2/15 1930, to 3/19 1930

that I last saw her alive on 3/18/30, 19

and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 (Address) 1345 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Albany N. Y.

20 UNDERTAKER ME Gosson.

DATE OF BURIAL March 20 1930

ADDRESS 844 W 37 Ho 11

Important. See instructions on back of this certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55294

CERTIFICATE OF DEATH

E 55294

REGISTERED No. 97

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St., 18-26 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Roswell Yates

(a) RESIDENCE NO. 906 Bechet Place

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day and year) 1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Yards
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Walter Yates

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Edw. Yates
(Address) 823 W. Stewart St

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Homicide due to Hemorrhage due to Pistol wound of Chest

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bradley & Pine

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) H. Leland Mitchell, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wellville Va — DATE OF BURIAL 3-20-1930

20 UNDERTAKER David Earlow — ADDRESS Home

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55295

CERTIFICATE OF DEATH

161-1002 E 55295

REGISTERED NO. 34

1—PLACE OF DEATH
CITY OF BALTIMORE, (No. South Baltimore General Hospital ST., (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Oliver E. Lubin Jr.

(a) RESIDENCE NO. 1631 Bell ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 18, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	*

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS
10 NAME OF FATHER: Oliver E Lubin Sr
11 BIRTHPLACE OF FATHER (city or town) (State or country): 1631 Bell St
12 MAIDEN NAME OF MOTHER: Frances A. Frau
13 BIRTHPLACE OF MOTHER (city or town) (State or country): U.S.A.

14 Informant: Parents
(Address): 1631 Bell St

15 Filed 2 0 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-19-30

17 I HEREBY CERTIFY, That I attended deceased from 3-18, 1930, to 3-19, 1930
that I last saw him alive on 3-19, 1930
and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:
Intracranial Hemorrhage
(New-born)
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? Physical Signs
What test confirmed diagnosis?
(Signed) Joseph H. Kaukaris, M. D.
(Address) South Baltimore Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olive Cem
DATE OF BURIAL: March 21 1930

20 UNDERTAKER: C. Howard Evans
ADDRESS: 3[illegible] E Fort Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55296 90 E 55296

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 609 S. Chapel St. St. 2-4 Ward)

2-FULL NAME Stanislaus Lijewski

(a) RESIDENCE NO. 609 S. Chapel St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Labor
(b) General nature of industry, business, or establishment in which employed (or employer) Steel
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Michael Lijewski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Frank Lijewski
(Address) 609 S. Chapel

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MAR 20 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

CONTRIBUTORY (Secondary) Pneumonia (duration) 1 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What confirmed diagnosis?

Mar 20/30

(Signed) M. D.

, 19 (Address) 143 N. Bonaparte

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cem. Rosary March 22 1930

20 UNDERTAKER John W. Wilson & Son

ADDRESS 1100 Chester

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Muhlhan ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55297

CERTIFICATE OF DEATH

49 E 55297

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Poplar Grove ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME HENRY F. MUHLHAN

(a) RESIDENCE NO. 1003 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Muhlhan

6 DATE OF BIRTH (month, day, and year) June 21, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer Retired 11 years

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Muhlhan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Anna Muhlhan (Wife)

(Address) 1003 Poplar Grove St.

15 Filed MAR 20 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1924 to March 20, 1930 that I last saw h— alive on March 14, 1930 and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma Prostate Gland

(duration) — yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes No Date of Nov 1929

Was there an autopsy?

What test confirmed diagnosis? Lab.

(Signed) Dan Gundelfinger, M. D.

3/20 1930 (Address) 5 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL Mar. 23 1930

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS BALTIMORE ST & BROADWAY

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55298 E 55298

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (ST.) 12-14 (WARD)

2-FULL NAME Mr Martin V.B. White

(a) RESIDENCE NO. 115 E. Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Loretto White

6 DATE OF BIRTH (month, day, and year): 85 Y

7 AGE: Years 77; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance

(b) General nature of industry, business, or establishment in which employed (or employer): 97

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Atlantic Ocean

PARENTS

10 NAME OF FATHER: Laurence White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cath Nolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Jas. L. Naughton (Address): 3113 Fairlie St Pittsburg Pa

15 Filed: 20 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-20 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-15, 1930, to 3-20, 1930, that I last saw him alive on 3-20, 1930, and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis with decompensation nephritis. Hypertension

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: 3/24 1930

20 UNDERTAKER: J. F. Fahey & Sons

ADDRESS: 131 E Biddle

CAUSE OF DEATH to be filled in this form, so that it may be possible.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55299

CERTIFICATE OF DEATH.

47 E 55299

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 4-25 WARD)

2-FULL NAME Mrs. Lillie Downey

(a) RESIDENCE NO. 657 N. Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Downey

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 57 | Months | Days | If LESS than 1 day, hrs. or ..min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hagerstown Maryland

PARENTS

10 NAME OF FATHER: Gregonia

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hagerstown Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hagerstown Maryland

14 Informant: Mr Daniel Downey
(Address) 657 N Fayett St

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

MAR 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/20/30 19

17 I HEREBY CERTIFY, That I attended deceased from 3/3/30 . 19 . to 3/20/30 . 19 . that I last saw her alive on 3/20/30 . 19 . and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

carcinoma breast

(duration) yrs. 14 mos ds.

CONTRIBUTORY (Secondary) toxemia

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm Deaver Chaney, M. D.

, 19 (Address) 24 St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Cemetery

DATE OF BURIAL: March 22 1930

20 UNDERTAKER: Louis J Heumann

ADDRESS: 32 S Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Josephine M Purcell.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55300

CERTIFICATE OF DEATH

3 1 √

REGISTERED NO. E 55300

1-PLACE OF DEATH

City of Baltimore: (No.) 1517 Clifton St. (3-54 Ward)

2-FULL NAME Ida M Purcell

(a) RESIDENCE NO. 1517 Clifton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7th 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
65	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Frank A Zimmerman

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Dehen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Guy H Zimmerman
(Address) 1517 Clifton

15 Filed ... 1930 ... Registrar

For RPK

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. TB.

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Eye

(Signed) H C Slade, M. D.

, 19 (Address) 1436 Penna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western	Mar 22 1930
20 UNDERTAKER	ADDRESS
John Fields	1200 W Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23753 E 55301 101-001 E 55301

CERTIFICATE OF DEATH

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Ebb

(a) RESIDENCE NO. 1114 Madison ave ST., WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer J. H. University

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 3-21 19 30 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18-30

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1930, to March 18, 1930, that I last saw him alive on March 18, 1930 and that death occurred, on the date stated above, at 12 10 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

— (duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Alexander Cantor, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 3/21/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill

MAR 21 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 55302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24 ✓

E 55302

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. No 1 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virginia Gatton

(a) RESIDENCE NO. 1133 S Clinton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Webster Gatton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Webster Gatton

(Address) 1133 S. Clinton St

15 Filed ..., 19 HAMILTON JONES, M. D. Registrar

MAR 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to March 19, 1930, that I last saw h.r. alive on March 19, 1930 and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis (Meningococcic)

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood & Lumbar puncture

(Signed) Myron G. Fuller, M. D.

3/21, 1930 (Address) Sydenham Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Saicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dr Laura Cent	March 21 1930
20 UNDERTAKER	ADDRESS
Leffler Funeral Home	[illegible]

Cor.—10-10-29—A Co.—100 Bks.

E 55303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

18 1-001

E 55303

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at the

City of Baltimore: (No. South Baltimore General Hospital St. 23-34 Ward)

2-FULL NAME Theodore Drager.

(a) RESIDENCE NO. 54 E. Randall St. St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Drager.

6 DATE OF BIRTH (month, day, and year) February 12, 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	60	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Marine Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer) 030
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Francis Drager.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Amelia Smith.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia.

14 Informant Mary Drager. (wife)
(Address) 54 E. Randall St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MAR 21 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Illuminating Gas poisoning.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 54 E. Randall St. March 18, 1930.

Did an operation precede death? No. Date of .....

Was there an antopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto M. Steinhardt, M. D.

3/19. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	March 20 1930
20 UNDERTAKER Lilly & Feiler Inc.	ADDRESS 1443 S. Hoyt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55304

CERTIFICATE OF DEATH

F 165 E 55304

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 4-7 Ward)

2-FULL NAME LeRoy A. Smith.

(a) RESIDENCE NO. 27 Admiral Blvd. Dundalk, Balto Co. Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 10, 1906

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	23	11	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Asst. Manager
(b) General nature of industry, business, or establishment in which employed (or employer) Reed Drug Co. Of
(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania.
(State or country)

PARENTS

10 NAME OF FATHER William F. Smith.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Daisy D. Morrow.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania.

14 Informant William F. Smith. (father)
(Address) 27 Admiral Blvd. Dundalk.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cyanide of Potassium Poisoning.
Suicide.
(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Howard & Franklin sts. March 19, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt M. D.

3/19, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Mar 22 1930

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

MAR 24 1930

Spec.—2-29-28—L. F. S.—500 Bks.

Ida H. Tyler ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55305 — CERTIFICATE OF DEATH — 129 E 55305

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) 1410 Webster ST. 24-34 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida H. Tyler

(a) RESIDENCE NO. 1410 Webster ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Levin D Tyler

6 DATE OF BIRTH (month, day, and year) Oct 3 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Henry Condon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Rachel A Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Edith H. Tyler

(Address) 1410 Webster St

15 Filed MAR 21 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1930

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1930 to March 19, 1930

that I last saw her alive on March 18, 1930

and that death occurred, on the date stated above, at 10 55 a.m.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

Chronic nephritis (duration) 6 yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Maylard R Wells M. D.

. 19 (Address) 1325 E. Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL Mar 22 1930

20 UNDERTAKER John H. Denny — ADDRESS 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55306

CERTIFICATE OF DEATH

E 55306

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 4-7 Ward)

2-FULL NAME George Bernard.

(a) RESIDENCE NO. Los Angeles, Calif. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	87	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sailor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report, C.D.
(Address)

15 Filed ... 19 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Embolism.
Traumatic amputation of the foot.
Accidentally run over by a street car.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Exeter near Platt St
Did an operation precede death? Yes. Date of March 18, 1930
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto M. Fernandez, M. D.
3/18, 1930 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A. A. Co. — DATE OF BURIAL Mar 21 1930

20 UNDERTAKER John F. Denny — ADDRESS 75 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 55307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 E 55307

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1609 N. Carey St ST. 15-59 WARD

2-FULL NAME Martha Brown

(a) RESIDENCE NO. 1609 N. Carey St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 ds. 3 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-17-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		3	3	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dorothy Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Dorothy Brown

(Address) 1609 N. Carey St.

15 Filed ....., 19 ..... Registrar

R 21-1930 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20-1930

17 I HEREBY CERTIFY, That I attended deceased from 3-18-, 1930, to 3-20, 1930, that I last saw h[illegible] alive on 3-20, 1930, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George Page M. D.

3-21-1930 (Address) 15 N. Mouton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Mar. 22 1930

20 UNDERTAKER Samuel F. Shaw & Son

ADDRESS 400 Mosher

TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

234891 Gyn E 55308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001 E 55308

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Myrtle Perry

(a) RESIDENCE NO. 3118 Dillon St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J Perry.

6 DATE OF BIRTH (month, day, and year) Aug 6, 1892

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Bean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophie Shroeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed MAR 21 1930 CLAYTON L. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to March 16, 1930, that I last saw h.. alive on Mar. 16, 1930 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Post-operative shock following ventral hernia operation 8 hrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3-17-30

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Fred W Sieb, M. D.

3/19, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 3/22 1930

UNDERTAKER William Fiaschetti 1618 Eastern

ADDRESS

Important. See instructions on back of certificate

Cor.—10-10-29—A Co.—100 Bks.

E 55309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

65-001 E 55309

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 5-9 Ward)

2-FULL NAME Kermit Roden

(a) RESIDENCE NO. 1408 McElderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 1918

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	22			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Bernard Roden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Webb

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Bernard Roden
(Address) 1408 McElderry St

15 Filed ... 19... HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20-30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) (Stab wound of Jan 10th not Contributory (duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? at Hopkins Hospital

What test confirmed diagnosis?

(Signed) [signature], M. D.

3/21/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvery Cem	3-22 1930
20 UNDERTAKER	ADDRESS
Byron Knight	1218 McElderry St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REC 1930 FEB

R.U.K. Gen.

Cor.—10-10-29—A Co.—100 Blks.

E 55310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 55310

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2115 Cliftwood Ave St., 8-45 Ward)

2-FULL NAME Amelia Cvetkovich

(a) RESIDENCE NO. 2115 Cliftwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3/1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		4	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Vasa Cvetkovich

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Servia

12 MAIDEN NAME OF MOTHER Christina Ryan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hungaria

14 Informant Father
(Address) 2115 Cliftwood Ave

15 Filed MAR 21 1930, 19 C. HARRISON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19/30 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia

(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contrarted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

3/21/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon PK. DATE OF BURIAL March 21 1930

20 UNDERTAKER E. Jones ADDRESS 411 S. Gilmor

Spec.—1-30—M. & T.—250 Bks.

E 55311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 E 55311

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 401 N. Glover, ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Baerschmidt

(a) RESIDENCE NO. 401 N. Glover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? 88 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Baerschmidt

6 DATE OF BIRTH (month, day, and year) DEC. 13 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. John Baerschmidt (Address) 401 N. Glover

15 Filed APR 2 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 20 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-15, 1930 to 3-20, 1930.

that I last saw her alive on , 19

and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cardiac Dilatation

(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Duncan M. D.

(Address) 1130 Madison Ave

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL March 24 1930

20 UNDERTAKER Henry Hock's Sons, Inc. ADDRESS Roy E. Eyerly

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55312

CERTIFICATE OF DEATH. 90

REGISTERED NO. E 55312

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St. 10-12 WARD)

2-FULL NAME Mr Vincent Louis

(a) RESIDENCE NO. 626 Frederick Rd Catonsville ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occ[illegible] mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) Oct 15, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
43		5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Anthony Louis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Teresa Grazia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Mary Louis 626 Frederick road

15 [illegible] C. HAMILTON JONES, M. D. Registrar

MAR 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-8 1930 to 3-19 1930, that I last saw h[illegible] alive on 3-19 1930, and that death occurred, on the date stated above, at 8 55 a m.

The CAUSE OF DEATH* was as follows:

hypertension, chronic myocarditis with Cardiac decompensation

Casting (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL March 22 1930

20 UNDERTAKER Frank V. Pepitone

ADDRESS 2515 E. Biddle st

CAUSE OF DEATH in plain terms. Indefinite answers will not be accepted. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 55313

CERTIFICATE OF DEATH

E 55313

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 3308 Noble st ST. 26-11 WARD)

2—FULL NAME Paolini Vincenzo Jr.

(a) RESIDENCE NO. 3308 Noble st ST. [redacted] WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30 1929

7 AGE: Years | Months: 6 | Days: 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Paolini Vincenzo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Margaret Brunero

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Paolini Vincenzo

(Address) 3308 Noble st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20/30

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to March 20, 1930,

that I last saw h[redacted] alive on March 20, 1930,

and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Philibert Artigiani M. D.

, 19 (Address) 2942 E Fayette st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL March 22 1930

20 UNDERTAKER Frank V. Pepitone

ADDRESS 2518 E. Belto[illegible]

HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55314 129 ✓

CERTIFICATE OF DEATH

REGISTERED NO. E 55314

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Lyon ST. 11-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alberta Taylor

(a) RESIDENCE NO. 524 Lyon St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 8 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Taylor

6 DATE OF BIRTH (month, day, and year): 7-10-1880

7 AGE: Years 49 | Months 8 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in whirh einployed (or employer): /

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Jeremiah Garrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Lydia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Jeremiah Garrison

(Address): 524 Lyon St.

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-18-30

17 I HEREBY CERTIFY, That I attended deceased from 3-11 1930 to 3-18 1930

that I last saw her alive on March 18, 1930

and that death ocrurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiovascular-renal Complications

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical, Lab.

(Signed) H Maceo Williams M. D.

3-19-1930 (Address) 1830 Madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: 3/22 1930

20 UNDERTAKER: Samuel Hemsley

ADDRESS 878 N Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

E 55315

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 55315

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 714 Pierce ST. 17-76 (WARD)

(REGISTERED NO.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Tate

(a) RESIDENCE NO. 714 Pierce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of George Tate

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
34 35		3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife, 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER William Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Hattie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Tate

(Address) 714 Pierce St

15 Filed MAR 21 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 16 1930, to March 18 1930

that I last saw h[illegible] alive on March 18 1930 12 25 P.M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Mar. 21, 1930

20 UNDERTAKER Mrs. Kate R. Williams

ADDRESS 322 N. Schroeder St

Spec.—1-12-23—M&T—500 Bks.

Geuste

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55316

90 E 55316

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 669 Portland ST. 22-30 WARD)

2-FULL NAME Caroline Geuste.

(a) RESIDENCE NO. 669 Portland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geuste.

6 DATE OF BIRTH (month, day, and year) Dec. 11. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	86.	4.	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Herman Goyert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Tuellach.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Myers.

(Address) 669 Portland St

15 Filed MAR 21 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/18/30. 19

17 I HEREBY CERTIFY, That I attended deceased from Dec. 11. 1929. to March 18. 1930.

that I last saw her alive on Mar 18. 1930.

and that death occurred, on the date stated above, at 6. P.M.

The CAUSE OF DEATH* was as follows:

Chr Endocarditis 3 yrs

Arteris Sclerosis 5 "

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Asenetaty & Opthyonomeld

(Signed) J M Dilnett M. D.

(Address) 671 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem't.

DATE OF BURIAL 3/22/30. 19

20 UNDERTAKER Geo Leimbach & Son

ADDRESS 520 W Lombard St

HAROLD R. JONES, M. D. Registrar

R.M.C.

FROM is very important. See instructions on back of Certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55317 202 ✓ E 55317

CERTIFICATE OF DEATH

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital, St., 26-37 Ward)

2-FULL NAME Maud Shirley Forsythe

(a) RESIDENCE NO. 3808 Clairmount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov 17-1929

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Walter Forsythe

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Ida M. Stoltz

13 BIRTHPLACE OF MOTHER (city or town) Henderson
(State or country) Md

14 Informant Ida M. Forsythe
(Address) 3808 Clairmount St

15 Filed ..... 19... C. HAMPSON PHILLIPS, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

acc asphyxia due to d
piece of meat

0 (duration) ... yrs. ... mos. 1/2 hr. ds.

CONTRIBUTORY Exhaustion
(Secondary)

(duration) ... yrs. ... mos. 1/2 ds.

18 Where was disease contracted — If not at place of death? —

Was operation performed? — Date of —

Was there an autopsy? —

Were tests confirmed diagnosis? —

(Signed) C. C. Wades, M. D.

(Address) 436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL 3/22 19 30

20 UNDERTAKER Henry Lutz

ADDRESS 1203 Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 55318

55318

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Md Gen Hosp ST. (or WARD) 16-68

2—FULL NAME Louis Haegerich

(a) RESIDENCE NO. 1109 Lombard ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Haegerich

6 DATE OF BIRTH (month, day, and year) Dec 23. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Haegerich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Albertina Hilsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address)

15 Filed ... 19 ... C. HUNTER JONES, M. D. Registrar

MAR 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 19/30

17 I HEREBY CERTIFY, That I attended deceased from 2/13/30, 19... to 3/19/30, 19...

that I last saw h~~e~~ alive on 3/19/30, 19...

and that death occurred, on the date stated above, at 920 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rt. Kidney

3 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? yes Date of 3/18/30

Was there an autopsy? no

What test confirmed diagnosis? Clinical

Signed Jno A Humphris M. D.

1109 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL Mar 22 19 30

20 UNDERTAKER Mr. Mrs. J. W. Teufel & Son

ADDRESS 21 W. Fayette

Cor.—10-10-29—A Co.—100 Bks.

55319

HEALTH DEPARTMENT—CITY OF BALTIMORE

55319

CERTIFICATE OF DEATH

188-103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St., 1-1 Ward)

2-FULL NAME Mary E. Jacobs

(a) RESIDENCE NO. 3068 Boston St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Jacobs

6 DATE OF BIRTH (month, day, and year) Sept 2- 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	79	1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Don't Know
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know
(State or country)

14 Informant Henrietta Dorn
(Address) 250 S Fitch St.

15 Filed ... 1930 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract Skull (Completely Crushed) ran over by loaded Vans truck accidental (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? Front of 3032 Boston St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. J. Hamm, M. D.

3/21, 1930 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem

DATE OF BURIAL Mch. 23 1930

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupations is important. See instructions on back of certificate.

MAR 21 1930

Spec.—2-29-28—L. F. S.—500 Blks.

E 55320

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ E 55320

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 713 N. Callington ST., 7th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James W. Hart

(a) RESIDENCE NO. 713 N. Callington ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 25 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
		5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Jas. J. Hart

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary J. Byrnes

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant James J. Hart (Address) 713 N. Callington

15 Filed [illegible] 19 [illegible] Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 19, 1930, to Mar 20, 1930, that I last saw h[illegible] alive on Mar 20, 1930, and that death occurred, on the date stated above, at 8-20 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

Mch 21, 1930 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Mch. 22 30
20 UNDERTAKER	ADDRESS
William E. Schaffer	1816 Monument

Spec.—1-30—M. & T.—250 Blks.

E 55321 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55321

CERTIFICATE OF DEATH.

90

REGISTERED NO. 71

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 506 Nottingham Road St., (Ward) 28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Blackhead

(a) RESIDENCE No. 506 Nottingham Road St., 10 Hills WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widower

5a If ~~married~~, widowed, or ~~divorced~~

HUSBAND of (or) ~~WIFE of~~ Kate Margaret Ray Blackhead

6 DATE OF BIRTH (month, day, and year) Aug 24 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ? Braun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Virginia L Blackhead

(Address) 506 Nottingham Road 10 Hills

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

APR 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to March 21, 1930, that I last saw h.im alive on March 20, 1930, and that death occurred, on the date stated above, at 2 AM.

The CAUSE OF DEATH* was as follows:

Thrombosis,

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary & Cerebral Embolism, Cardiac failure (duration) yrs. mos. 6 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Was Signs

(Signed) H. A. Scruggs, M. D.

3/21, 1930 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old St Pauls Howard Co Md

DATE OF BURIAL March 24 1930

20 UNDERTAKER Henry Hankins & Co

ADDRESS Oakland Md

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55322

CERTIFICATE OF DEATH.

90 E 55322

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2334 W. Balto. St. 20-64 (WARD)

2-FULL NAME Lottie Edna Litchfield

(a) RESIDENCE NO. 2334 W Balto ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. M. Litchfield

6 DATE OF BIRTH (month, day, and year) February 1880

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
50	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER William H. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Amelia Jane Crumpton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant George M. Litchfield
(Address) 2334 W. Baltimore Street

15 Filed MAR 21 1930, 19 [illegible] Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 1 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/5/30, 19 ..... to 3/1/30, 1930

that I last saw h[illegible] alive on 3/1/30, 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) [illegible], M. D.

3/20/30 (Address) 375 Stricker St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Mar. 22 1930

20 UNDERTAKER George L. Schwartz ADDRESS 1101 Eutaw Ave.

TION is very important See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

Dr Link

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 55323

CERTIFICATE OF DEATH

90

REGISTERED NO. B 55323

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1215 Bolton St., 11-24 (Ward)

2-FULL NAME F. Stuart Hopkins

(a) RESIDENCE NO. 1215 Bolton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1 2

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
About	74			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant (Retired)
(b) General nature of industry, business, or establishment in which employed (or employer) " "
(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER James H. Hopkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary C Stuart

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Wm S. Fuller
(Address) 1704 Huntington Ave

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and find that said deceased came to death (Autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Rob't Smith, M. D.

May 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 5/22/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Enter statement of occupation as one important. See instructions on back of certificate.

21 1930

Spec.—8-16-29—L. F. S.—100 Blks.

E 55324

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 55324

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp St. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fred Cook.

(a) RESIDENCE NO. 1013 Greenmount Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Louisa C.

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer) or

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Frederick Cook

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah A. —

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Chas. W. Marsh

(Address) 831 Greenmount Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20/30.

17 I HEREBY CERTIFY, That I attended deceased from 3/15/30, 19..; to 3/20, 19 30, that I last saw him alive on 3/20, 19 30. and that death occurred, on the date stated above, at 2-20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchio - pneumonia.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes. Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry D. Ulrich, M. D.

19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/24/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Important. See instructions on back of certificate.

3-21-30 THOMPSON JONES M.D.

ACH

Spec.—8-16-29—L. F. S.—100 Blks.

E 55325

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 129

E 55325

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 41 ST. WARD)

2—FULL NAME Sister Mary Stephen Gillian

(a) RESIDENCE NO. Dominican Convent ST. Catonsville 2nd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 days How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) 65

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Gillian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mercy Hospital Records (Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

R 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/30

17 I HEREBY CERTIFY, That I attended deceased from 3/18/30, 19..., to 3/31/30, 19..., that I last saw h e alive on 3/31/30, 19..., and that death occurred, on the date stated above, at 9 20 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 5 da.

CONTRIBUTORY (Secondary) Chronic Nephritis & Uremia

(duration) ... yrs ... mos. ... da.

18 Where was disease contracted if not at place of death? at Dominican Convent

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) David Jenner, M. D.

3/31/30 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dominican Convent Catonsville Md.

DATE OF BURIAL Mar 24 30

20 UNDERTAKER Chas P. Travers & Son

ADDRESS 1180 W. Royal Ave

Important. See instructions on back of certificate.

Spec. 1-30—M. & T.—250 Blks.

E 55326 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 55326

CERTIFICATE OF DEATH.

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. St 5-8 WARD)

2-FULL NAME Alice Collins (Barnes)

(a) RESIDENCE NO. 237 Forrest St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harrison Barnes

6 DATE OF BIRTH (month, day, and year) 1900 Oct

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	29?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER William Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Harriet Bobbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Record (Address)

15 Filed 3-21-1930, 19 RKH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18-30

17 I HEREBY CERTIFY, That I attended deceased from 2-12, 1930, to 3-18, 1930, that I last saw h[illegible] alive on 3-18, 1930, and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows:

Ulcerations of vulva and thighs

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

3-20 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Astral Evergreen Cemetery

DATE OF BURIAL 3/22 1930

20 UNDERTAKER Wm. Chas. E. Burley

ADDRESS 17 & Jefferson St

C. HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55327

CERTIFICATE OF DEATH.

69

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO. 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette & Calhoun ST. WARD

2-FULL NAME Betty Low Carlson

(a) RESIDENCE NO. 5315 Cordelia Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 19-1920

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Wm Carlson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Erma V. Smallwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John W. Carlson

(Address) 5315 Cordelia Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to March 21, 1930, that I last saw her alive on March 21, 1930, and that death occurred, on the date stated above, at 6:35 P m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Diathesis of new born

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Franklin Square Hospital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Profuse Bleeding from Rectum

(Signed) M.B. Schreiber, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilson Cemetery — DATE OF BURIAL: 3/24/30

20 UNDERTAKER: Harry Altvater — ADDRESS: 401 Edmondson

C. GAMPER JONES, M. D.

21 1930

CAUSE OF DEATH in plain terms. No abbreviations or symbols. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55328 90 ✓ E 55328

CERTIFICATE OF DEATH

REGISTERED NO. 27-44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2805 Southern Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E. Hampsher

(a) RESIDENCE NO. 2805 Southern Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Dottie Hampsher

6 DATE OF BIRTH (month, day, and year) July 6 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Jacob B. Hampsher

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Comfort Stabler

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Dottie Hampsher
(Address) 2805 Southern Ave

15 Filed ... 19 ... C. HAMPSON JONES M. D. Registrar
MAR 22 1930 Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20-1930

17 I HEREBY CERTIFY, That I attended deceased from 9/1, 1929, to 3/20, 1930, that I last saw h... alive on 3/20, 1930 and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Arteris-sclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Strutt, M. D.

3/24, 1930 (Address) 440 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middletown Md.

DATE OF BURIAL 3/23 19

20 UNDERTAKER I. Few McCully

ADDRESS 130 E Fort.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55329 129 E 55329

REGISTERED NO. 4-6-23

1-PLACE OF DEATH

City of BALTIMORE: (No. 1022 Stockton

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Taylor

(a) RESIDENCE NO. 1022 stockton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Curtis Taylor

6 DATE OF BIRTH (month, day, and year) June 15, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	51	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer none

9 BIRTHPLACE (city or town) King & Queen Co

(State or country) Virginia

PARENTS

10 NAME OF FATHER Peter Robinson

11 BIRTHPLACE OF FATHER (City or town) King & Queen Co

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) King & Queen Co

(State or country) Virginia

14 Informant Mary Wheeler

(Address) 1503 W. Lanvale St.

15 Filed 3-22-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20-1930

17 I HEREBY CERTIFY, That I attended deceased from 2-2-, 1930, to 3-19-, 1930, that I last saw her alive on 3-19-, 1930, and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory + Physical diagnosis

(Signed) Frank P. Saunders, M. D.

3-20-1930 (Address) 1029 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Md

Date of Burial Mar 22 1930

UNDERTAKER Virginia A Brooks

ADDRESS 1418 3d Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55330

CERTIFICATE OF DEATH

129 E 55330

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Caroline ST. 10-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cora Spillman

(a) RESIDENCE NO. 116 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 6 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 12th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	63	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress (Machine)

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Spillman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lindsager

13 BIRTHPLACE OF MOTHER (city or town) Cumberland (State or country) Md

14 Informant Nan Spillman

(Address) 716 N. Caroline

15 Filed ... 19 ... C. HAMPSON JONES, M. Registrar

22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to March 21, 1930, that I last saw h[illegible] alive on March 20, 1930 and that death ocrurred, on the date stated above, at 10 A M m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Clare S. Bishop, M. D.

1930 (Address) 1512-26th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL March 24 1930

ADDRESS

20 UNDERTAKER George Schilling & Sons 1126 E Monument St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55331 88 E 55331

CERTIFICATE OF DEATH

E 55331 REGISTERED NO.

I—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3031 Walbrook Ave 5-67 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lola Ruth Watkins

(a) RESIDENCE NO. 3031 Walbrook Ave ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/21/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Lola Hare

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Watkins (Address) 3031 Walbrook ave

Filed MAR 22 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 16, 1930, to Mar 21, 1930, that I last saw her alive on Mar 20, 1930, and that death occurred, on the date stated above, at 5-55 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ans.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E Miles Wheeler, M. D.

3-21, 1930 (Address) 212 Mount ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery DATE OF BURIAL 3/24/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul st

Important. See instructions on reverse side before writing.

Spec.—1-30—M. & T.—250 Bks.

E 55332

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55332

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. ..... ST. 23-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nagle

(a) RESIDENCE NO. 50 E Randall ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed.

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Anna unknown.

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Nagle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records. Baltimore City Hospitals (Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to March 20, 1930, that I last saw him alive on March 20, 1930, and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic + acute

(duration) unknown. yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown. yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical exam.

(Signed) Paul Padget. M. D.

3-21, 1930 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 3/24/1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

MAR 22 1930

Spec.—1-30—M. & T.—250 Blks

Dr Kieffer 1462 Washington Blvd

E 55333

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55333

CERTIFICATE OF DEATH.

REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2247 Annapolis Rd St.) (25-32 WARD)

2-FULL NAME Edward E. Wahl Jr

(a) RESIDENCE No. 2247 Annapolis Rd St., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/12/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Edward E Wahl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Francis Coleman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Edward E. Wahl

(Address) 2247 Annapolis Blvd

Filed 3-22-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21/30

17 I HEREBY CERTIFY, That I attended deceased from Mch 12, 1930, to Mch 21, 1930, that I last saw h[illegible] alive on Mch 21, 1930, and that death occurred, on the date stated above, at 6-30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) G. Kieffer, M. D.

(Address) 1462 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL 3/22/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION IS VERY important. See instructions on

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55334

CERTIFICATE OF DEATH

129 E 55334

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1303 Walnut Ave Rognd Hughes St., 28th W.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Katherine Walton

(a) RESIDENCE NO. 1303 Walnut Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ric Walton

6 DATE OF BIRTH (month, day, and year) August 26 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
47			24	
48	6	22		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick C Kluth

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Elizabeth Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Maria Elizabeth Miller

(Address) 504 Fulton Ave.

15 Filed 19 Registrar

ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1928, to 3-20, 1930, that I last saw h[illegible] alive on 3-20, 1930, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Uremia - Nephritis - Chronic myocarditis

hypertension (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Geo. P. Wiseley, M. D.

. 19 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilson Cemetery

Date of Burial Mar 21 1930

20 UNDERTAKER Wilbur W Sherwood

ADDRESS 4000 Edmondson ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 22 1930

Spec.—8-16-29—L. F. S.—100 Bks.

2345-04 D 55335

HEALTH DEPARTMENT—CITY OF BALTIMORE

33 D 55335

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Jackson

(a) RESIDENCE NO. 2324 Guilford ST., ire WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Jackson

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Usa — (State or country)

PARENTS

10 NAME OF FATHER Thomas Jackson

11 BIRTHPLACE OF FATHER (city or town) Va — (State or country)

12 MAIDEN NAME OF MOTHER Maria Edwards

13 BIRTHPLACE OF MOTHER (city or town) Md — (State or country)

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed 3-22-1930 G. HAWKINS LOWES M. D. Registrar RKA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar - 21 - 30

17

I HEREBY CERTIFY, That I attended deceased from Feb 28, 1930, to March 21, 1930, that I last saw h[illegible] alive on Mar. 21 1930 and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) yrs. 7 2 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? P.M. examination

(Signed) Alexander Winter, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Long Green, Balto Co, Md

DATE OF BURIAL: Mar. 24 1930

20 UNDERTAKER: C. Broadt & Son

ADDRESS: Sparrows Md.

Important. See instructions on back of certificate

Spec.—8-16-29—L. E. S.—100 Bks.

E 55336

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

232691 Med

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~JOHNS HOPKINS HOSPITAL~~ St. 4-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Stewart

(a) RESIDENCE NO. 508 N Lafayette Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Richard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Harriet Bolton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... Registrar

C. THAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-18-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to 3-18, 1930, that I last saw h... alive on 3-18, 1930, and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Arteriosclerosis

(duration) yrs. 6 mos. — da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Alexander Custis M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westmorland Co Va

DATE OF BURIAL Mar 22 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

Important: See instructions on back of Certificate

Spec.—2-29-28—L. F. S.—500 Bks.

E 55337

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55337

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 N. Fanvals ST. 16-22 WARD)

2—FULL NAME Francis Lohun

(a) RESIDENCE NO. 1603 N. Fanvals ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of: Rev. Geo. Lohun

6 DATE OF BIRTH (month, day, and year): Feb 5 1876

7 AGE — Years: 54 — Months: 1 — Days: 16 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General House wmd.

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Robt. Buchanan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Martha Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Malala Leeds

(Address) 1603 N. Fanvals

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 21, 30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 13 1929 to Mar 20 1930

that I last saw h[illegible] alive on Mar 20 1930

and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Auto-Toxemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Hepatic Cancer

(duration) 1 yrs. 4 mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Lafayettes, M. D.

3/21/30 (Address) 1012 N. Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Spesutie Va.

DATE OF BURIAL: Mar 23 19 30

20 UNDERTAKER: Thomas E. Kelson.

ADDRESS 1303 Pennsylvania ST

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55338

CERTIFICATE OF DEATH

100-001

REGISTERED NO. E 55338

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3711 Liberty Heights Ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. McClellan

(a) RESIDENCE NO. 3711 Liberty Heights Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 25th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Library

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm W. McClellan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Maria D. Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) La Plata Charles Co Md

14 Informant Mrs. Edward Bonn Lamb

(Address) 2315 N. Calvert St

15 Filed 3 22 1930 Registrar ARK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15th 1930, to March 20, 1930, that I last saw him alive on March 20th, 1930 and that death occurred, on the date stated above, at 10.00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) 0 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) ~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. L. Lull, M. D.

3/20, 1930 (Address) 3711 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Cem. Fayette & Green Sts

20 UNDERTAKER Henry W. Jenkins' Sons Co.

DATE OF BURIAL 3/24 1930

ADDRESS Orchard & McCulloh

Important. See instructions on back of certificate.

Spec—12-23-2(—E.B.R.S.—400 Blks.

E 55339

HEALTH DEPARTMENT—CITY OF BALTIMORE

55339

CERTIFICATE OF DEATH.

161-001

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 925 N. Gilmor St. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Healy Th

(a) Residence No. 925 N. Gilmor St St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 3/21/30

7-AGE Premature yrs. mos. ds.

If LESS than 1 day, hrs. or 3 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Thomas Sale

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Annie Custis

13-BIRTHPLACE OF MOTHER (city or town) Cape Charles (State or Country). Virginia

11- (Informant)

(Address) JOHNS HOPKINS HOSPITAL

15- Filed 193 Registrar.

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3/21/30

17- I HEREBY CERTIFY, That I attended deceased from 3/21/ 19 30 to Mar 21 19 30 that I last saw h[illegible] alive on 3/21/ 19 30, and that death occurred, on the date stated above, at 5.23 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity (2 5 wks

Gestation and atelectasis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? (Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank T. Woody Jr. M. D.

3/21/ 19 30 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

Commissioner Health. MAR 22 1930

Wm. F. WOODALL

instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55340

74-001

E 55340

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Garage Manager near Preston & Gay (Ward)

2-FULL NAME Geo. C. Hutton

(a) RESIDENCE NO. 2105 Windsor St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah A.

6 DATE OF BIRTH (month, day, and year): Aug 13- 1873

7 AGE: Years 56 | Months 7 | Days 5 | IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Milk Driver
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Geo C. Hutton

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Harris

13 BIRTHPLACE OF MOTHER (city or town) Little Pa
(State or country)

14 Informant Edith L. Norman
(Address) 1614 N. Fulton

15 Filed _____, 19__ C. HAMPSON JONES, M. D. Registrar

R 21330

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Sudden

(duration) _____ yrs.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) J. H. Lusk M. D. Coroner

(Address) _____

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Park — DATE OF BURIAL: June 1 1930

20 UNDERTAKER: H. H. Ehlen — ADDRESS: W. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55341

129 ✓

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 1416 Harford ave ST., 9-18 WARD)

2-FULL NAME Charles Thomas Martin

(a) RESIDENCE NO. 1416 Harford ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Dec. 7, 1880

7 AGE: Years 49 | Months 3 | Days 12 | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED:
(a) Trade, profession or particular kind of work: Shipping Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Notion
(c) Name of employer: Nathan, Horsinger & Co Balto Md

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wesley Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary McGlothlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Irene Wallace 407 Harford ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 18 1930

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1930, to Mar 17, 1930, that I last saw h[illegible] alive on March 17, 1930, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Chr Interstal Nephritis
Anuria

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Calvin B Lecompte M. D.

, 19 (Address) 1113 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem.

DATE OF BURIAL: Mch 23 1930

20 UNDERTAKER: Mrs J. G. Soc. Inc.

ADDRESS: 1302 Jefferson

22 1930

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55342

E 55342

129

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1625 E. 32d ST., 9-4th WARD)

2-FULL NAME Justina Davis Parker

(a) RESIDENCE NO. 1625 E. 32d ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Parker

6 DATE OF BIRTH (month, day, and year) July 17-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	78	7	27	

8 OCCUPATION OF DECEASED none

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) formerly housekeeper

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Phoenixville, Pa.

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country) Wales

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country) Not known

14 Informant Mrs. Bernard H. Staples

(Address) 1625 E. 32d St.

15 Filed Mar 22 1930, 19 [illegible] Registrar

C. JAMES [illegible], M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan —, 19 21, to March 21, 19 30,

that I last saw h[illegible] alive on March 20, 19 30,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation following influenza

(duration) several years mos. ds.

CONTRIBUTORY (Secondary) [illegible] (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

March 22, 19 30 (Address) 1014 S. Grand Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL March 24 19 30

20 UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager st

Spec.—2-29-28—L. F. S.—500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55343 — 33V 55343

CERTIFICATE OF DEATH

REGISTERED NO. 14-20

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Madison Ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert C Johnson

(a) RESIDENCE NO. 1704 Madison Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married.

6a If married, widowed, or divorced HUSBAND of (or WIFE of) Mamie Johnson

6 DATE OF BIRTH (month, day, and year) March 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 40

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Middlesex Co Va.

PARENTS

10 NAME OF FATHER Robert B. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Middlesex Co Va

12 MAIDEN NAME OF MOTHER Hannah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) King & Queen Co Va

14 Interment Mrs Mary Osborne

(Address) 809 Argyle St

15 Filed 2 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1 1930 to March 21 1930

that I last saw him alive on March 20 1930

and that death occurred, on the date stated above, at 6 10 A. m.

The CAUSE OF DEATH* was as follows:

~~Stomach~~ Entero-Colitis

(Probably Tuberculous)

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Hemmorrhage

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R F Yeatman, M. D.

3/22 1930 (Address) 1429 Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middlesex County Va

DATE OF BURIAL 3/23 1930

20 UNDERTAKER Wm Chas H. Bibby

ADDRESS 1421 Jefferson St

Spec.—8-16-29—[illegible]—100 Bks.

(Annie Williams)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55344

38 E 55344

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 n Eden ST. 5 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME annie williams

(a) RESIDENCE NO. 118 n Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John williams

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER al Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) va

12 MAIDEN NAME OF MOTHER Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John williams

(Address) 118 n Eden st

15 Filed ..... 19 ..... Registrar

APR 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 18, 1930 to Mar 20, 1930, that I last saw h[illegible] alive on Mar 20, 1930 and that death occurred, on the date stated above, at 9.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Cebreal apoplexy

(duration) yrs. mos. 14 da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Sachs, M. D.

3/21, 1930 (Address) 380 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery

DATE OF BURIAL march 23, 1930

20 UNDERTAKER Edward Borgas

ADDRESS 1631 orleans st

IMPORTANT.—SEE INSTRUCTIONS ON BACK OF CERTIFICATE

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55345 — 24-001 — E 55345

REGISTERED NO. 4-25

1—PLACE OF DEATH. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 644 Josephine ST., WARD)

2—FULL NAME Thomas Perry

(a) RESIDENCE NO. 644 Josephine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of Lula Perry

6 DATE OF BIRTH (month, day, and year) March 15-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Anthony

11 BIRTHPLACE OF FATHER (city or town) (State or country) Antigua

12 MAIDEN NAME OF MOTHER Martha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Antigua

14 Informant Lula Perry (Address) 644 Josephine St

15 Filed ... 19 ... Registrar

22 1930 C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1930, to March 18, 1930, that I last saw h[illegible] alive on March 16, 1930, and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Tenley, M. D.

19 (Address) 1001 Gay St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem — DATE OF BURIAL 3/22/30

20 UNDERTAKER Samuel Tenley — ADDRESS 1001 Gay St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55346 — CERTIFICATE OF DEATH — REGISTERED NO. E 55346

1—PLACE OF DEATH
CITY OF BALTIMORE: (No.) 33rd and Calvert Streets (Street) Union Memorial Hospital (Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna Smith

(a) RESIDENCE NO. 2515 Asquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 29, 1914

7 AGE: 15 Years | 11 Months | 20 Days | If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Student
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt. Vernon, N. Y.

PARENTS
10 NAME OF FATHER George A. Smith
11 BIRTHPLACE OF FATHER (city or town) (State or country) New York City
12 MAIDEN NAME OF MOTHER Edna Butler
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Martinsburg W. Va

14 Informant George A. Smith
(Address) 2515 Asquith St

15 Filed APR 2 1930, 19 — Registrar C. HAMPSON JONES, M. D.
By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930 to March 20, 1930
that I last saw her alive on March 20, 1930
and that death occurred, on the date stated above, at 8.15 P. m.
The CAUSE OF DEATH* was as follows: Staphylococcus Septicemia

(duration) yrs. 2 mos. 7 ds.
CONTRIBUTORY (Secondary) Coronary Sinus Thrombosis
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? — Date of —
Was there an autopsy? No Laboratory Findings
What test confirmed diagnosis?
(Signed) S. R. Miller Path. U. M. H.
3/20, 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery | DATE OF BURIAL: March 22 19 30

20 UNDERTAKER: Edmonston Bell Stamper & Co. | ADDRESS: Phila

Spec.—1-30—M. & T.—250 Blks.

E 55347 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55347

38

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 213 N Carrollton St (Hosp.) 46-26 (WARD)

2-FULL NAME Charles Moore

(a) RESIDENCE NO. 213 N Carrollton St WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE: 50 (Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer): Coal Yard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Mabel Burton
(Address) 213 N Carrollton

15 Filed ..... 19..... Registrar

MAR 27 1930 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20/30

17 I HEREBY CERTIFY, That I attended deceased from 3/10/30, 19..., to 3/20/30, 19..., that I last saw him alive on 3/20/30, 19..., and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Asthma

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Theodore Dorsey, M. D.

19 (Address) 1 W Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 3-23 1930

20 UNDERTAKER: Daniel Corbett — ADDRESS 916 Penna

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55348 — 170 — E 55348

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2203 Eutaw Pl St. (Ward) 11-30

2-FULL NAME Isaac Strauss

(a) RESIDENCE NO. 2203 Eutaw Pl St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida B Strauss

6 DATE OF BIRTH (month, day, and year) Dec 10 - 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	63	3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothier
(b) General nature of industry, business, or establishment in which employed (or employer) Mfg
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Moses Strauss

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Stern

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Ralph Weshnin
(Address) 2230 Linden Av

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Gun Shot Temple
22 Cal. Revolver

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Sick

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did operation precede death? — Date of —

Was there an autopsy? May 24 30

What test confirmed diagnosis? —

(Signed) J C Eddis M. D.

19 (Address) 1436 W Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew Cem

DATE OF BURIAL 3/23 1930

ADDRESS

20 UNDERTAKER J Tahmus Co

2431 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

2[illegible]-1930

Spec.—8-16-29—L. F. S.—100 Blks.

234950 E 55349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 45 ✓ E 55349

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. (WARD) 17-11a

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Layne

(a) RESIDENCE NO. 754 Bradley ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June-15-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ 021

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) VA

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Henrietta Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

APR 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-20-30

17 I HEREBY CERTIFY, That I attended deceased from March-14, 1930, to March 20, 1930, that I last saw her alive on March 20, 1930 and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

Post-Operative Shock —

(duration) Layne ds.

CONTRIBUTORY Malnutrition, ~~Chronic Nephritis~~ Arteriosclerosis, Chronic Nephritis (Secondary) (duration) 2+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? natural course

Did an operation precede death? Yes Date of 3-20-30

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) W. S. Everett M. D.

3/20, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg, Va

DATE OF BURIAL Mar 23, 1930

20 UNDERTAKER Mrs Kate R. Williams

ADDRESS 3224 Edmondson Ave

Important: See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55350 — CERTIFICATE OF DEATH — 114 E 55350

1—PLACE OF DEATH Md. General Hospital — REGISTERED NO. 16-68

CITY OF BALTIMORE: (No. ... ST ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Olive Stanke

(a) RESIDENCE NO. 2824 Winchester ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 04 yrs. 11 mos. 20 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Mr. Stanke Edwin W.

6 DATE OF BIRTH (month, day, and year) 3/28/1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas E. Sinclair

11 BIRTHPLACE OF FATHER (city or town) Lightners (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fiddes

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country) Md.

14 Informant Hospital record (Address)

15 Filed MAR 23 1930 Registrar

16 Prepared by HARRISON-JONES M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20/30

17 I HEREBY CERTIFY, That I attended deceased from 3/19, 1930, to 3/20, 1930, that I last saw h alive on 3/20, 1930 and that death occurred, on the date stated above, at 9:40 A.m.

The CAUSE OF DEATH* was as follows:

Acute dilation (cause unknown)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible] M. D.

3/20/1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mar 24 1930

UNDERTAKER Wm J. Ficknen Sons — ADDRESS N. Ave & Pa

Important.

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55351

90 E 55351

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 619 N. Fremont St., (Ward) 17-26

2-FULL NAME Burton Wallace

(a) RESIDENCE NO. 619 N. Fremont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Victoria Wallace

6 DATE OF BIRTH (month, day, and year): Dec 5-1889

7 AGE: Years 30 | Months 3 | Days 15 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): C&O
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dalto Co. Md

PARENTS

10 NAME OF FATHER: Jos. Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Victorie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Victoria Wallace
(Address): 619 N. Fremont

15 Filed MAR 23 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 20th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) Sudden

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. E. Smith M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brook Chapel — DATE OF BURIAL: 3-23-1930

20 UNDERTAKER: Cal. & Md — ADDRESS: 1087 Druid Hill

John N Jordan

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55352

CERTIFICATE OF DEATH.

100-001

E 55352

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 728 N. Carey St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Grafton Campbell

(a) Residence No. 728 N. Carey St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	C	✓

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year) July 4, 1923

7-AGE 6 yrs. 7 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Henry Campbell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Calvert Co. Md.

12-MAIDEN NAME OF MOTHER, Ida Wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md.

14- (Informant) Ida Campbell

(Address) 728 N. Carey St.

15- Filed ..... 192.. C. HUMPSON JONES, M. D. Registrar.

R 23 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 3-20-30

17- I HEREBY CERTIFY, That I attended deceased from 3-16-, 1930 to 3-19-, 1930 that I last saw him alive on 3-19-, 1930 and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. M. Lawrence, M. D.

, 19 (Address) 1232 Hoshen St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Mch 23, 1930
20-UNDERTAKER. John A. Graham	ADDRESS 1627 Edmondson

Please write plainly. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 55353

REGISTERED NO. E 55353

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. 818 Edmondson Ave) (WARD) 6-16

2—FULL NAME John W Johnson

(a) RESIDENCE NO. 818 Edmondson Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	married

a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Hannah Johnson

6 DATE OF BIRTH (month, day and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clabors.

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford County Md

PARENTS

10 NAME OF FATHER Sledrick Johnson

11 BIRTHPLACE OF FATHER (city or town) Hartford County (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah Preston

13 BIRTHPLACE OF MOTHER (city or town) Harford Co (State or country) Md

14 Informant Malcolm Johnson (Son)

(Address) 818 Edmondson Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17 1930 to March 19 1930.

that I last saw h[er] alive on March 19 1930 at 8.45 P m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Hypertension (duration) 7 yrs. mos. 3 ds. Cardio-Renal Disease (duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Typical findings & Symptoms

(Signed) George McDonald M. D.

19 (Address) 908 W Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clark Chapel

DATE OF BURIAL 3/23 1930

20 UNDERTAKER Samuel J Mosley

ADDRESS 578 McCulloh

MAR 23 1930 C. HUMPHREYS, M.D.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 55354

CERTIFICATE OF DEATH.

74-001

B 55354

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital ST. 10-14 WARD)

2-FULL NAME Mrs. Ollie Hutton

(a) RESIDENCE NO. 1215 N. Central Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Hutton

6 DATE OF BIRTH (month, day, and year): Oct 26, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work at

(b) General nature of industry, business, or establishment in which employed (or employer): Home 637

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Kavanaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Mrs Mabel Mary Vaughn 1215 N. Central Ave

15 Filed MAR 23 1930 By C. HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 26 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-20, 1930, to 3-21-30, 19....,

that I last saw her alive on 3-21-30, 19....,

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical sign.

(Signed) W B Hendrix M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pankenwood Cemetery

DATE OF BURIAL: Mar 25, 1930

UNDERTAKER: Elmer W. Conklin

ADDRESS: 924 E. Eager St.

CAUSE OF DEATH must be given in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 55355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 55355

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 812 E. Eager ST. 10-14 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rabuck J. Burns

(a) RESIDENCE NO. 812 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugenia Burns/Mc Aheron

6 DATE OF BIRTH (month, day, and year) Dec 1, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman water Dept for 30

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto city

9 BIRTHPLACE (city or town) (State or country) Annapolis Md.

PARENTS

10 NAME OF FATHER James Burns.

11 BIRTHPLACE OF FATHER (city or town) (State or country) annapolis.

12 MAIDEN NAME OF MOTHER Margaret Dempsey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Edw. P. Burns. (Address) 394 Fremont.

15 Filed 19 Registrar

MAR 25 1930 G. HAMILTON ROYSTER, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21st 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 25 1930 to Mar 21 1930, that I last saw he live on Mar 21 1930, and that death occurred, on the date stated above, at 12 00 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs. 24 mos

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm Ernest Black M.D.

19 (Address) 719 Med Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Mar 25, 1930

20 UNDERTAKER Edmon W. Conklin ADDRESS 924 E. Eager St.

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55356

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55356

1024

CERTIFICATE OF DEATH

REGISTERED NO. 13-51

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. Gilbert & 33rd Sts. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Flurley Perryman

(a) RESIDENCE NO. 3507 Poole St ST. Balt. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 mos 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 16, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	16	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country)

PARENTS

10 NAME OF FATHER Harvey Perryman.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Elsie Fredrick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Uncle and Aunt

(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Mar 20th, 1930, to March 22, 1930, that I last saw h. er alive on Mar. 22, 1930 and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical course.

(Signed) Francis W Lueck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt Carmel Balto Co

DATE OF BURIAL March 24, 1930

20 UNDERTAKER Ehrenwerth & Son

ADDRESS 3917 Chestnut Ave

Important. See instructions on reverse side.

H. E. BUC. HOPKINS, M. D.

Per ... Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

E 55357

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55357

CERTIFICATE OF DEATH

REGISTERED NO. 90 Mt. Washington

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 1900 Sulgrave Av ST. 27-54 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gilson Grant Blake

(a) RESIDENCE NO. 1900 Sulgrave Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Alice L Blake

6 DATE OF BIRTH (month, day, and year) Oct 28 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Textile Manager

(b) General nature of industry, business, or establishment in which employed (or employer): 86

(c) Name of employer: Lyle Mills

9 BIRTHPLACE (city or town) (State or country): Buffalo N Y

PARENTS

10 NAME OF FATHER: Jos B. Blake

11 BIRTHPLACE OF FATHER (city or town) (State or country): Buffalo New York

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Mrs Blake

(Address) 1901 Sulgrave Av

15 Filed ..... 19 ..... Registrar

APR 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21-30

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1928, to March 21, 1930, that I last saw h[illegible] alive on March 20, 1930 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiac disease.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) 0 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

March 22 1930 (Address) 842 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Mar 24 30
20 UNDERTAKER	ADDRESS
A S Marshall	3539 Fallsway

Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 55358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. × 31

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 707 W. Saratoga St., (Ward) 4-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara E. Mitchell

(a) RESIDENCE NO. 707 W. Saratoga St. Ward 9½

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carlton Mitchell

6 DATE OF BIRTH (month, day, and year) 7/14 1868

7 AGE Years 62 Months 7 Days 7 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Wash. Jaynie

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Martha Capscott

13 BIRTHPLACE OF MOTHER (city or town) Va.

(State or country)

14 Informant Rose Lavinia Carter

(Address) 707 W. Saratoga St.

16 Filed ..... 19 ..... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1930

17

I HEREBY CERTIFY, That I attended deceased from Mar 9, 1930, to Mar 21, 1930, that I last saw h[illegible] alive on Mar 21, 1930, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis all lobes both lungs; Chronic Myocarditis, Cardiac (duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) E. Howard Tonolla M. D.

, 19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Co Va — Date of Burial 3/23 1930

20 UNDERTAKER J. F. Shaffer Sons — ADDRESS 13 N Eighty St.

OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55359 ✓ E 55359

CERTIFICATE OF DEATH.

REGISTERED NO. 31

E 55359

1-PLACE OF DEATH Baltimore City Hospitals (T. B.) 3-4

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hasty

(a) RESIDENCE NO. 315 S. Caroline st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly

(b) General nature of Industry, business, or establishment in which employed (or employer) Hospital 086

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Hasty

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie McDowney

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Hospital Records
(Address)

15 Filed MAR 25 1930, 19 ..... HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 19 30, to March 21, 19 30, that I last saw him alive on March 21, 19 30, and that death occurred, on the date stated above, at 3.20 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas. Thorald Jr. M. D.

3-21 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL Mar. 24 1930

20 UNDERTAKER Mrs. E. Miller & Son

ADDRESS 2334 Jefferson St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55360 31 E 55360

CERTIFICATE OF DEATH

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3742 Hickory Ave ST., (WARD) 23

2—FULL NAME Jessie L. French

(a) RESIDENCE NO. 3742 Hickory Ave ST., WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 4 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Toma French

6 DATE OF BIRTH (month, day, and year): Nov. 18-1898

7 AGE — Years: 31 | Months: 4 | Days: 4 | If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer): 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George A. French

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rosie L. Chaffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Rosie L. French

(Address): 3742 Hickory Ave.

15 Filed ____ 19 ____ C. HUMPTON JONES, M. D. Registrar

R 23 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 22-1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930, to March 22, 1930,

that I last saw him alive on March 21, 1930

and that death occurred, on the date stated above, at 4-50 A. m.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) ____ (duration) ____ yrs. ____ mos. ____ da.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Chaffin, M. D.

19 (Address) 9 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Hampden — DATE OF BURIAL: March 24 1930.

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 363 Falls Road

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55361 62 ✓ E 55361

CERTIFICATE OF DEATH

E 55361 REGISTERED NO. 5563

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Edith Harriett Schwartzman

(a) RESIDENCE NO. 3935 Boarman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March-14-30

7 AGE	Years	Months	Days 8	If LESS than 1 day, ...hrs. or ....min.
			9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Ellis Schwartzman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sophie Feldman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Hospital Record

(Address)

15 Filed ....., 19 ..... PHL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1930.

17 I HEREBY CERTIFY, That I attended deceased from Mar 14, 1930, to Mar 22, 1930, that I last saw her alive on March 22, 1930 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows: Meningeal Hydrocephalus

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

13 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Ira A Hampton M. D.

3/23/30 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel

DATE OF BURIAL 3-23-1930

20 UNDERTAKER Jack Lewis, 1439

ADDRESS E. Baltimore

Important. See instructions on reverse side.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 55362 49 B 55362

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital ST. 15-21 WARD)

CITY OF BALTIMORE: (No.

2-FULL NAME Joseph Silverstein

(a) RESIDENCE NO. 1616 N. Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Lena Silverstein

6 DATE OF BIRTH (month, day, and year) Lenkeram

7 AGE Years 61 Months Days If LESS than 1 day, brs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lena Silverstein (Address) 1616 N. Appleton St

15 Filed MAR 29 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1930

17 I HEREBY CERTIFY, That I attended deceased from 12-7 1929 to 3-22 1930.

that I last saw him alive on 3-22 1930,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

rank (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) terminal Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam

(Signed) J. H. Cohn, M. D.

3/31, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cemetery

DATE OF BURIAL 3/23 1930

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St

CAUSE OF DEATH to plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55363 51 E 55363

CERTIFICATE OF DEATH

REGISTERED NO. 2435

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hosp. ST. (If not in hospital or institution, give WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William McHale

(a) RESIDENCE NO. 115 E Hall ST., 84 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Mary Glynn

6 DATE OF BIRTH (month, day, and year) — — 85

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Telly clerk

(b) General nature of industry, business, or establishment in which employed (or employer): V 009

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm McHale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Julia McHale

(Address) 1323 Eutaw St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21/30

17 I HEREBY CERTIFY, That I attended deceased from 2/16, 1930, to 3/21, 1930

that I last saw h[im] alive on 3/21, 1930

and that death occurred, on the date stated above, at 3:35 p.m.

The CAUSE OF DEATH* was as follows:

(a) Staphylococcus Septicemia

(b) Diabetes mellitus

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/10 Thomas abscess L. Leg

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory examination

(Signed) Thos. E. Stoltz Jr., M. D.

, 19 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Hill

DATE OF BURIAL 3/25 1930

20 UNDERTAKER: J. F. Schaefers

ADDRESS 1918 Light St

Important. See instructions on reverse side.

Cor.—10-10-29—A Co.—100 Bk

Krug

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55364

185 E 55364

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. City Hospital St. 1-1 Ward)

2-FULL NAME Anna E Krug

(a) RESIDENCE NO. 820 S Curley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jacob. Krug

6 DATE OF BIRTH (month, day, and year) Aug 31, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	51	6	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Casper Hobka

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr. Jacob. Krug
(Address) 820 S. Curley St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest; autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental fall in her home

Central Haemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where did such disease contracted — ?
Was it at place of death? — ?
Had an operation preceded death? — Date of — ?
Was there an autopsy? — ?
What test confirmed diagnosis? History

(Signed) G E Glades, M. D.

19 (Address) 143 B Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Mar. 24 1930

20 UNDERTAKER John A Moran

ADDRESS 3000 E Balto St

MAR 23 1930 C. HANSON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

235165
Med. 55365

CERTIFICATE OF DEATH

× 90

E 55365

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Allen

(a) RESIDENCE NO. 4000 Clairmont ST., WARD
(Usual place of abode) Birmingham, Ala.
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Margaret

6 DATE OF BIRTH (month, day, and year) July 1, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Charles M. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Nanny Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Margaret H. Allen
(Address) Birmingham Ala

15 Filed ... 19 ... Registrar

C. HERBERT JONES, C. E.
MAR 23 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23-30

17 I HEREBY CERTIFY, That I attended deceased from 3-20-, 1930, to 3-22-, 1930, that I last saw him alive on 3-23-, 1930 and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease
(Cerebral embolism)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral embolism
Hemiplegia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Birmingham Ala

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? ~~yes~~

(Signed) [illegible], M. D.

Mar 23, 1930 (Address) 1208 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Birmingham Ala

DATE OF BURIAL Mch 23 1930

20 UNDERTAKER John O. Mitchell Jones & Evans

ADDRESS Eutaw Place

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55366

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55366

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No.) ST. 11-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lida O'Donnell

(a) RESIDENCE NO. 1013 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 31, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford County (State or country) Md.

PARENTS

10 NAME OF FATHER George O'Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann Ham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records Of BALTIMORE CITY HOSPITALS (Address)

15 Filed ..... 19.. Registrar

MAR 26 1930 BALTIMORE CITY HOSPITALS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to March 21, 1930, that I last saw h alive on March 21, 1930, and that death occurred, on the date stated above, at 5:00 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute.

Move than 5 yrs. mos. ds.
(duration)

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Paul Padget, M. D.

3-22, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Cem Hickory Md

DATE OF BURIAL March 24 1930

20 UNDERTAKER Joseph D Cook

ADDRESS 1003 N Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

E 55367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

14 901 ✓ E 55367

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 N. Kenwood Ave. ST. 6 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Horisberg

(a) RESIDENCE NO. 115 N. Kenwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer William Jones Grand Secretary I.O.O.F.

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Horisberg

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna C. Schmink

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mr. William A. Jones

(Address) 706 N. Gilmor St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/6 19 29, to 3/21 19 30, that I last saw her alive on 3/21 19 30, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2½ ds.

Essential Hypertension

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Dr. Dorsey, M. D.

3/22 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Mar. 24 1930

20 UNDERTAKER Frank B. Cook

ADDRESS 1003 West Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

55368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28 B 55368

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Johns Hopkins Hospital St., 4-46 Ward)

2-FULL NAME James C. Shea

(a) RESIDENCE NO. 606 Bartlett Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3/1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	22	7	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Drug Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Bowman
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Co., Md.

PARENTS

10 NAME OF FATHER John Shea

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Co., Md.

12 MAIDEN NAME OF MOTHER Agnes Croghan

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co., Md.
(State or country)

14 Informant Mrs. Agnes Shea
(Address) 606 Bartlett Ave

15 Filed MAR 23 1930 16 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 21-30 Mar 21-30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Rabies- bitten by dog Jan 14/30
(Reported to have been bitten
2317 Garrett Ave)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature] M. D.

3/22/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Mar 24 1930
20 UNDERTAKER Mary M Wedefeld	ADDRESS 60 E 22nd

Information should be carefully supplied. Any omission or error in the information given will delay the issuance of a permit. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55369 99-01 E 55369

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2129 Homewood ave ST.) (WARD) 99-46

2-FULL NAME James E. Hughes

(a) RESIDENCE NO. 2129 Homewood ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ (late) Margaret Hughes

6 DATE OF BIRTH (month, day, and year) 12-3-1838

7 AGE: 91 Years, 4 Months, 18 Days. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Williamsport, Pa.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Hughes

11 BIRTHPLACE OF FATHER (city or town) Williamsport, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Clarke

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Mrs Joseph Cottier
(Address) 2129 Homewood

15 Filed ..... 19 ..... Registrar .....

R 23 1930 C. HAMPSON JAMES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 13th, 1930, to March 21st, 1930, that I last saw him alive on March 20th, 1930 and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Heart Failure (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Reginald S. Towns, M. D.

3-23 1930 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL March 24 1930

20 UNDERTAKER Mary M Medefield

ADDRESS 501 E 22nd

CAUSE OF DEATH in plain terms, so that it may be properly classified. PART STATEMENT OF COMPLICATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E.55370 HEALTH DEPARTMENT—CITY OF BALTIMORE E.55370

CERTIFICATE OF DEATH.

REGISTERED NO. 6212 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1201- N. Luzerne ST., WARD)

2-FULL NAME Maria Schulze

(a) RESIDENCE NO. 1201- N. Luzerne ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl F. Schulze

6 DATE OF BIRTH (month, day, and year) Dec 6 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	65	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carl A. Schulze

(Address) 1201 N. Luzerne

15 Filed MAR 24 1930, 19.... Registrar C. HARRY JONES, M. D. RWL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21/1930

17 I HEREBY CERTIFY, That I attended deceased from 3/17/1930, to 3/21/1930

that I last saw h alive on 3/21/1930

and that death occurred, on the date stated above, at 9.30 9 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes

Acute Arthritis -

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Diabetic coma -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Sugar & Albumin in Urine

(Signed) J. A. Bowden, M. D.

3/23 1930 (Address) 1517 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 3/24/1930

UNDERTAKER J. Mary J. Pfeltz

ADDRESS 1235 Hayward

CAUSE OF DEATH. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55371

90 E 55371

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 688 E. Clement St. St. 24-33 Ward)

2-FULL NAME Leo J. Kelly.

(a) RESIDENCE NO. 688 E. Clement St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~WIFE OF~~ Margaret Kelly.

6 DATE OF BIRTH (month, day, and year) April 10, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	50	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist.
(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John H. Kelly.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Lestner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Margaret Kelly. (wife)
(Address) 688 E. Clement St.

15 Filed ..... 19.. C. HUBERT HOLMES, M. D. Registrar

MAR 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhard, M. D.

3/22. 1930 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Mar. 24 1930
20 UNDERTAKER Margaret E. Flynn	ADDRESS 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55372

CERTIFICATE OF DEATH.

129 E 55372

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 No. Carey St S 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Maria Crawford

(a) RESIDENCE NO. 105 No. Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25th. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel C. Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Belle Clemson

(Address) 105 No. Carey St.

15 Filed APR 24 1930, 19 C. HAWKINS JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1930, to March 22 1930,

that I last saw h[illegible] alive on March. 19, 1930,

and that death occurred, on the date stated above, at 1.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 7 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Bronchio pneumonia

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Chas. D. Kemsley, M. D.

, 19 (Address) 1730 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/24 1930

20 UNDERTAKER Harry N. Witzke

ADDRESS 4101 Edmondson Ave

HON is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55373

CERTIFICATE OF DEATH

90 E 55373

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 920 Argyle St. 17-24 Ward)

2-FULL NAME Bettie Proctor

(a) RESIDENCE NO. 920 Argyle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 26 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	53	—	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Md

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Howard Turner
(Address) 920 Argyle St

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

MAR 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Mar 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..yrs. 3 mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. Leland Mackenzie M. D.
Mar 21 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Mch 24 1930

20 UNDERTAKER Wm. H. Foulkrod

ADDRESS 1127 Rend Ave

IMPORTANT—Undertaker should be careful that every question is answered so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55374

E 55374

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Parkin ST. 18-24 (WARD)

2-FULL NAME JOSEPH STRAIMIKIS

(a) RESIDENCE NO. 24 Parkin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No. 60

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Litvania

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Litvania

12 MAIDEN NAME OF MOTHER No

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Litvania

14 Informant N. Straimikis

(Address) 24 Parkin Street

15 Filed MAR 24 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1930, to Mar. 21, 1930, that I last saw h[illegible] alive on Mar. 21, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Myocarditis. Chronic

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Thos. C. Blake, M. D.

3/24, 1930 (Address) 719 Mid. Auto Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislowas	March 26, 1930
UNDERTAKER	ADDRESS
John Grebliauckas	433 S Paca St.

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55375

REGISTERED NO. 90 E 55375

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2206 E Hoffman St., 8-16 WARD)

2-FULL NAME Caroline Walters

(a) RESIDENCE NO. 2206 E Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Walters

6 DATE OF BIRTH (month, day, and year) Oct 25th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	4	29	

8 OCCUPATION OF DECEASED At home

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gabeker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Frank J Snyder

(Address) 2206 E Hoffman St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1928, to March 22, 1930,

that I last saw her alive on March 24, 1930,

and that death occurred, on the date stated above, at 7.20 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis +

Senile regurgitation

(duration) 2 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical tests,

(Signed) Albert Bingaman M. D.

3/23 1930 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem

DATE OF BURIAL Mar 25-30.

20 UNDERTAKER John Ellrich

ADDRESS 2008 Orleans

TION is very important. See instructions on

2A 1930 C H

Spec—1-30—M. & T.—250 Blks.

55376 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55376

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1731 N Chester ST. 8-16 WARD)

2-FULL NAME Charles F Schmidt

(a) RESIDENCE NO. 1731 N Chester ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M Schmidt

6 DATE OF BIRTH (month, day, and year) July 9-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER Hubert Schmidt
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Amelia Schmidt
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna M Schmidt
(Address) 1731 N Chester St

15 Filed MAR 24 1930 H. LAWRENCE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23-1930

17 I HEREBY CERTIFY, That I attended deceased from October 25, 1929 to March 23 1930,
that I last saw h[illegible] alive on March 23 1930,
and that death occurred, on the date stated above, at 6 50 a m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
Arterial Hypertension
(duration) 1 yrs. 6 mos ds.
CONTRIBUTORY (Secondary) Uraemia Exhausta
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No Was Examination Required?
What test confirmed diagnosis?
(Signed) Albert Ehrenfried M. D.
3/23 1930 (Address) 2025 E Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem
DATE OF BURIAL Mar 24 30
UNDERTAKER D. John Ulrich
ADDRESS 29 E Biddle

TION is very important. See instructions on back

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55377

CERTIFICATE OF DEATH.

100-001

E 55377
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. NO. 3644 Beech (ST.) 13 5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Esther Moxley.

(a) RESIDENCE. NO. 3644 Beech ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan 13/1930.

7 AGE — Years: 0 — Months: 2 — Days: 10 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto city Md

PARENTS

10 NAME OF FATHER: Raymond Moxley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Josephine Hare

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Josephine Moxley
(Address) 3644 Beech ave

15 Filed APR 24 1930 C. HAMPSON JONES, M. D. Registrar
Per Rich.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 13, 1930, to Mar 23, 1930, that I last saw h[illegible] alive on Mar 23, 1930, and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) Probable Pneumonia

preceding (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore P. [illegible], M. D.

3/24 1930 Address 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Evergreen — DATE OF BURIAL: 3/25/30

20 UNDERTAKER: J. Walter Davis — ADDRESS: 337 Paine st

CAUSE OF DEATH must be filled in. See instructions on back of certificates. TION is very important.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55378

113

E 55378

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 7-24 Ward)

2-FULL NAME James M. Briscoe

(a) RESIDENCE NO. 523 Moore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4/1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0/1/1	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Palto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Roy Briscoe

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Louise ---

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Roy Briscoe
(Address) 523 Moore St

15 Filed ... 19 C. HARRISON JONES, M. D.
Registrar
For

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Convulsions- (Cause undetermined probably gastro-intestinal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Briscoe, M. D.

3/24/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft. Auburn Cem

DATE OF BURIAL 3/24/1930

20 UNDERTAKER Samuel T. Hemsley

ADDRESS Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 24 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55379

E 55379
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. 2350 Mc Culloh St. 13-54 Ward)

2-FULL NAME James Robinson

(a) RESIDENCE NO. 2350 Mc Culloh St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lenora Robinson

6 DATE OF BIRTH (month, day, and year) Dec 22nd 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	37	2	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work General Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Wilmington
(State or country) Del

PARENTS

10 NAME OF FATHER George Robinson
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md
12 MAIDEN NAME OF MOTHER Harriett Brown
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Estelle M. Robinson
(Address) 2350 Mc Culloh St

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? No
What was confirmed diagnosis? History

(Signed) J. C. Clarke, M. D.

19 (Address) 4376 Finney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	3/24 1930
20 UNDERTAKER Samuel Hanselman	ADDRESS 1700 Bridle

This space to be carefully typewritten, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 55380 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55380

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 716 N. Lafayette St. 14-20 (WARD)

2-FULL NAME Nilda S. Tolson

(a) RESIDENCE NO. 716 N. Lafayette St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30-1918

7 AGE Years 11 Months 9 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Perry S. Tolson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Viola Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Perry S. Tolson (Address) 716 N. Lafayette St

15 Filed MAR 24 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/20/30

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to March 20, 1930, that I last saw h. alive on March 20, 1930, and that death occurred, on the date stated above, at 10-30 P.M.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C. Stewart, M. D.

, 19 (Address) 716 W Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 3/24 1930

20 UNDERTAKER Samuel A. Hinsley

ADDRESS W Baltimore

TION is very important See instructions on back of certificate

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55381

CERTIFICATE OF DEATH

101-001

E 55381

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard A Taylor

(a) RESIDENCE NO. 622 E 35th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ella Taylor

6 DATE OF BIRTH (month, day, and year) May 2nd 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman 073

(b) General nature of industry, business, or establishment in which employed (or employer) P. R.R.

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Geo H. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Caroline Dyke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Bertha M. Lewis

(Address) Brooklyn Md

15 Filed ... 19 ... Registrar

MAR 24 1930 C. H. LOUIS, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22 1930

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to March 22, 1930, that I last saw h alive on March 22, 1930 and that death occurred, on the date stated above, at 8 35 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Bradley Dodgens, M. D.

3-22 1930 (Address) U S Marine Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 3/26 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Fayette

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 55382 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55382

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4804 Park Heights Ave ST. 9-25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A. Walter

(a) RESIDENCE. NO. 631 N. Franklin ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucy O. Walter

6 DATE OF BIRTH (month, day, and year): Mar. 29. 1843

7 AGE: Years 86 Months 11 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman. Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Rochester

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mary G Smith 3103 Lawrence Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23a 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 26 . 1930 . to March 23 . 1930 . that I last saw him alive on March 18 . 1930 . and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Hansom & Silver, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dun Cathedral

DATE OF BURIAL: 3/25 1930

20 UNDERTAKER: J. M. Cook

ADDRESS: 1217 Park Ave

CAUSE OF DEATH. See instructions on back of certificate. TION is very important.

RECEIVED MAR 24 1930

Spec.—1-30—M. & T.—250 Blks

700 W. [illegible] Ave
E Baugh. Mad 6612

E 55383

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55383

CERTIFICATE OF DEATH.

90

REGISTERED NO. 15-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1514 Eutaw Pl ST., 15 WARD)

2-FULL NAME Annie Louise Reynolds

(a) RESIDENCE NO. 1514 Eutaw Pl ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Waring F.

6 DATE OF BIRTH (month, day, and year) Sept 29 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mrs Kenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md - Kenna

14 Informant Miss Brogan (Cousin)
(Address) 15 W Eutaw Pl

15 Filed 19 Registrar

C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 22 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 15, 1928 to Mch 22, 1930 that I last saw h[illegible] alive on Mch 22, 1930 and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
(Mitral Insufficiency)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Jamie Vaught M. D.
(Address) 700 W Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Mch. 25 1930	

20 UNDERTAKER H. M. Cook ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

Dr Thomas Med. Arts Bldg

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55384

E 55384

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1121 N. Fulton Ave 16-22 WARD)

2-FULL NAME Samuel Cleveland Billingsley

(a) RESIDENCE NO. 1121 N. Fulton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Elsye Billingsley

6 DATE OF BIRTH (month, day, and year) 2/16/1885

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tracer

(b) General nature of industry, business, or establishment in which employed (or employer) Automobile

(c) Name of employer Wld Piston Ring Co

9 BIRTHPLACE (city or town) (State or country) Missouri

PARENTS

10 NAME OF FATHER Walter Billingsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bettie Kaiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elsye Billingsley

(Address) 1121 N. Fulton Ave

15 Filed MAR 24 1930, 19 C. HAMPSON JONES, M. D. Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/21/30

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1929, to Mch 21, 1930,

that I last saw him alive on Mch 21, 1930,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Sarcoma Fr. Lung.

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray & other exam.

(Signed) Thos Delaney Thomas, M. D.

3/22 1930 (Address) 11 W Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 3/24/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55385

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55385

CERTIFICATE OF DEATH

145-001

REGISTERED NO. 6-416

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen M. Hardesty

(a) RESIDENCE NO. 3039 Frisby St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. Earl Hardesty

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1900

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Alexander B. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Judith Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va.

14 Informant Husband Records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1930, to Mar 22, 1930, that I last saw h.. alive on Mar 22, 1930, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows: Diabetes Mellitus

Pregnancy, Paralytic Ileus

Gastritis

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 10 min ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Mar 20, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

1317 [illegible] St (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 3/25/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

important. See instructions on back of certificate.

HAMPSHIRE JONES, M.

MAR 24 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55386

REGISTERED NO. **E 55386**

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1330 Woodyear St. 15-23 (Ward) 90

2-FULL NAME Lillie Ross.

(a) RESIDENCE NO. 1330 Woodyear St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clide Ross.

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Clide Johnson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mariette Buchanan

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Clide Ross
(Address) 1330 Woodyear

15 Filed ..... 19..... Registrar

MAR 24 1930 C. HAMILTON JONES M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Stenosis

(duration) yrs. mos. ds. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. H. Smith, M. D.

Mar 21 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Mar 24 1930
20 UNDERTAKER Virginia A Brooks	ADDRESS 1437 Carey

Post

Do not should be carefully examined before it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55387

CERTIFICATE OF DEATH

167-001

E 55387

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 422 S. Ann St. St., 2-4 Ward)

2-FULL NAME Adam Kerbeski

(a) RESIDENCE NO. 422 S. Ann St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Kerbeski

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Labor
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Johanna Kerbeski
(Address) 422 S. Ann St.

15 Filed MAR 24 1930 (J. HAMPSON JONES) Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide

Gas Poisoning-Ill.

(duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. 4 hr.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. Blades M. D.

. 19 (Address) 1436 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary March 24	1930
20 UNDERTAKER	ADDRESS
Adam Weber	701 Chester

Not to be used for statistical purposes. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90√ E 55388

1—PLACE OF DEATH

REGISTERED NO. 8-16

CITY OF BALTIMORE: (No. 1533 N. Fulton Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James O. Horak.

(a) RESIDENCE NO. 1533 N. Fulton Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sylvia B Horak

6 DATE OF BIRTH (month, day, and year) Aug 3-1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	25	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Burner helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Jos. Horak

11 BIRTHPLACE OF FATHER (city or town) Chicago Illinois

(State or country)

12 MAIDEN NAME OF MOTHER E. Mencura

13 BIRTHPLACE OF MOTHER (city or town) Chicago Illinois

(State or country)

14 Informant Sylvia B Horak

(Address) 1533 N. Fulton Ave

15 Filed APR 24 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22/30

17 I HEREBY CERTIFY, That I attended deceased from March 5 1929 to March 22 1930

that I last saw him alive on March 22 1930

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Trouble

(duration) 5 yrs. ....mos. ....da.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Hoyer M. D.

(Address) 809 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	3/26 19 30
20 UNDERTAKER L. J. Rauch	ADDRESS 640 S Eaton Ave

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55389.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55389 — CERTIFICATE OF DEATH — 129 — E 55389

1—PLACE OF DEATH University Hospital — REGISTERED NO. .....

CITY OF BALTIMORE: (No. Lombard + Greene Sts. 4-30 WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. King

(a) RESIDENCE NO. Eldridge, Md. St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Frederick Seiling

(Address) Eldridge, Md.

15 Filed APR 24 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24/30.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1930, to Mar 22, 1930

that I last saw him alive on Mar 23, 1930

and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH* was as follows:

Uremia
Hypostatic pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Walter B. Johnson, M. D.

Mar. 19 30 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Junc. Md

DATE OF BURIAL 3/26 1930

20 UNDERTAKER Edward N. Leiter

ADDRESS Laurel, Md.

important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 ✓

REGISTERED NO. **E 55390**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH **E 55390**

CITY OF BALTIMORE: (No. 4003 Tolney St. 15th WARD)

2—FULL NAME Jesse M. Spangler

(a) RESIDENCE NO. 4003 Tolney St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced, (or) WIFE of Charles W. Spangler

6 DATE OF BIRTH (month, day, and year) Nov 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Woodstock Va.

PARENTS

10 NAME OF FATHER Hord

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Charles W. Spangler

(Address) 4003 Tolney St.

15 Filed ... 19... Registrar ...

C. HAMPSON JONES

MAR 24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to March 25, 1930

that I last saw h... alive on March 19, 1930

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Adeno carcinoma. Ovary & metastasis throughout intestines - ascites.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Enterocolitis 6 min.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of Jan 1930

Was there an autopsy? no

What test confirmed diagnosis? microscope

(Signed) Thomas St. Nicholas M. D.

March 29, 1930 (Address) 904 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harlem Lawn Md. DATE OF BURIAL March 26 1930

20 UNDERTAKER Edw. C. Mitchell Sons and Co. ADDRESS

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55391

CERTIFICATE OF DEATH.

3/ E 55391

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1635 N Monroe ST. 15-21 (WARD)

2-FULL NAME Mrs Jennie L. Burton

(a) RESIDENCE NO. 1635 N Monroe ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Cont. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John S. Ryan

6 DATE OF BIRTH (month, day, and year): Sept 1856

7 AGE: Years 73; Months 6; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Illinois

PARENTS

10 NAME OF FATHER: Wm. Yorkshire

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Sarah Lauderbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Indiana

14 Informant (Address): Adrian F. Kluge 1635 N. Monroe St.

15 Filed Mch 25 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 23 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 24 1929 to Mch 23 1930, that I last saw her alive on Mch 20 1930, and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

Don't Know (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. H. Dewell, M. D.

Mch 19 30 (Address) 1817 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: 19 Mch 25 30

20 UNDERTAKER: John O. Mitchell Inc

ADDRESS: Pikesville

CAUSE OF DEATH. See instructions on back of certificates. TION is very important

HARRISON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 55392

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55392

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Maryland Ave. ST. 12-51 WARD)

2-FULL NAME Franklin W. Dryden

(a) RESIDENCE NO. 2118 Maryland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence M. Price

6 DATE OF BIRTH (month, day, and year) Apr. 28, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oil Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. H. Dryden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Hanway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co., Md.

14 Informant Mr. Thomas P. Dryden

(Address) 6212 Blackburn Lane

15 Filed MAR 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1930, to Mar. 21, 1930, that I last saw h[illegible] alive on March 21, 1930, and that death occurred, on the date stated above, at 9-18 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart due to Chronic Myocarditis and nephritis, Cardio Vascular Renal disease

(duration) yrs. 1, mos 27 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 14+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) M. Gibson Forter, M. D.

3/24, 1930 (Address) 4824 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Mar. 24, 1930

UNDERTAKER: John O. Mitchell & Sons — ADDRESS: 1900 Eutaw Pl.

John O. Mitchell

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

106-001

E 55393

CERTIFICATE OF DEATH.

E 55393

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital (WARD) S 28-64

CITY OF BALTIMORE: (NO. ST., WARD)

2-FULL NAME Frank Mace

(a) RESIDENCE NO. 4310 Main Ave (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ ooo

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Frank T. Mace Jr.

11 BIRTHPLACE OF FATHER (city or town) St Louis (State or country) Mo.

12 MAIDEN NAME OF MOTHER Hauf

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Frank T. Mace Jr.

(Address) 4310 Main Ave

15 Filed APR 24 1930 H. L. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/30

17 I HEREBY CERTIFY, That I attended deceased from 3-22, 1930, to 3-23, 1930, that I last saw him alive on 3-23, 1930, and that death occurred, on the date stated above, at 2 45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

3/23, 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL March 1930

20 UNDERTAKER Martin Fahey & Sons ADDRESS 1827 N Monroe

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

23454/ E 55394 100-99/ B 55394

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST 23-33 WARD)

2—FULL NAME Joseph Hartlove

(a) RESIDENCE NO. 30 E [redacted] Hamburg St ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 4-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant- gtd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Hartlove

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Irene Wroten

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Reads

(Address) [redacted]

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

MAR 24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 22, 1930 that I last saw him alive on March 22, 1930 and that death occurred, on the date stated above, at 4 15 p m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at hospital

Did an operation precede death? Yes Date of 3-15-30

Was there an autopsy? Yes Employee

What test confirmed diagnosis?

(Signed) R. O. G. Warren, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL March 24 1930

20 UNDERTAKER Marzack & Flynn

ADDRESS 1427 Eutaw St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55395

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55395

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 413 N. Highland Ave. ST. 76-11 WARD)

2—FULL NAME JULIA JERSCHEID ~~JERSCHEID~~

(a) RESIDENCE NO. 413 N. Highland Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced
HUSBAND of (or) WIFE of Christian Jerscheid

6 DATE OF BIRTH (month, day, and year) June 3,1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Wm. Schultz (Daughter)

(Address) 1603 E. 33rd Street

15 Filed MAR 24 1930 19 HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31. 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1930, to March 31, 1930, that I last saw her alive on March 29, 1930 and that death occurred, on the date stated above, at 1.20 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Louis Krause, M. D.

19 (Address) Med. Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery.

DATE OF BURIAL Mar. 24 1930

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS Baltimore St & Broadway

IMPORTANT.—See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 55396 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55396

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument - Rutland (St.) 3-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida Schwartz

(a) RESIDENCE NO. 520 - S. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Schwartz

6 DATE OF BIRTH (month, day, and year)

7 AGE: 73 Years — Months — Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Lazar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Lear

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Sam Schwartz 301 N. Carlton Ave

15 Filed [illegible] 19

C. HAMPSON JONES, M. D. Registrar

APR 24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/24 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/22, 1930, to 3/24, 1930, that I last saw her alive on 3/24, 1930, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis and myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical - Laboratory

(Signed) L. A. Silver, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 3/24 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55392

E 55397

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest Knelles

(a) RESIDENCE NO. Glenburnie ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna

6 DATE OF BIRTH (month, day, and year) Nov 26 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 087

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Friedrich Knelles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Hoke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wife (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20/30

17 I HEREBY CERTIFY, That I attended deceased from February 19, 1930, to March 20, 1930, that I last saw him alive on March 20, 1930, and that death occurred, on the date stated above, at 11-15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma in mediastinal glands and oesophagus with Oesophago-tracheal fistula (duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 3/6/30

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Edward Thompson M. D.

3/20/1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL March 24/1930

20 UNDERTAKER John F Denny

ADDRESS 715 Light St

Important. See instructions on back of certificates.

C. HARRISON JONES, M. D.

APR 24 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55398 ✓

CERTIFICATE OF DEATH

E 55398

1—PLACE OF DEATH

Brooklyn 31

REGISTERED NO. 73-32

CITY OF BALTIMORE: (No. 3453 Hanover ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mildred E Arnold

(a) RESIDENCE NO. 3453 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 11 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 25/913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Typist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Hughey L Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Jones Md

12 MAIDEN NAME OF MOTHER: Gertrude E Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Westmer Co Md

14 Informant: Mr Hughey L Arnold
(Address) 3453 Hanover st

15 Filed MAR 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20/930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1929, to Mar. 20, 1930, that I last saw her alive on Mar 20, 1930 and that death occurred, on the date stated above, at 10:05 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Indefinate
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell, M. D.

3/22, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: March 24 1930

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55399

E 55399

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 9-17 WARD)

2-FULL NAME Jacob Schnitzer

(a) RESIDENCE NO. Parkville; Old Harford Road ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. 18 ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 24 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... mi.
	70	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Schnitzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalena Schnitzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jos. A. Schnitzer (Address) Parkville Md.

15 Filed MAR 24 1930 Registrar C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-4- 1930 to 3-22 1930,

that I last saw him alive on 3-22- 1930,

and that death occurred, on the date stated above, at 10 55 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) ? yrs. ? mos ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) ? yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John V. Shaw M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 26 1930
20 UNDERTAKER	ADDRESS
Patrick Lesher	Long Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. PLACE number of house TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Marjorie Scott.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55400

CERTIFICATE OF DEATH.

21-001

E 55400

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 27-56 (WARD)

2-FULL NAME Marjory Scott.

(a) RESIDENCE NO. 3813 Buchler Ave. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 5 22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work, None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John P Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Minnie Arthur

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant John P Scott
(Address) 3813 Buchler

15 [illegible] C. HAMPSON JONES, M. D. Registrar

MAR 24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/7, 1930, to 3/22, 1930, that I last saw her alive on 3/22, 1930, and that death occurred, on the date stated above, at 2:15 A.m.

The CAUSE OF DEATH* was as follows:

Spinal meningitis -
Septicemia & pneumococcus infection. (duration) yrs. mos 19 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Pneumococcus.

(Signed) I. A. Silver, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Bur

DATE OF BURIAL Mar 24 1930

20 UNDERTAKER H M Courtenay

ADDRESS 2238 N Mott

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Cor.—10-10-20—A Co.—100 Bks.

E 55401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 55401

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Mem Hosp 9-47 St., Ward)

2-FULL NAME Silas W Ennis

(a) RESIDENCE NO. 624 Wyanoke Av Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christena D Ennis

6 DATE OF BIRTH (month, day, and year) Aug 8- 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) House Furnishings
(c) Name of employer

9 BIRTHPLACE (city or town) Quantico
(State or country) Va

PARENTS

10 NAME OF FATHER Rich. A. Ennis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Knox

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Kent Knox

14 Informant Louis A. Ennis
(Address) 3303 Devonshire Drive

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck & Knocked down by auto truck while crossing street

Fract Skull (duration) 2 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Fract Femur, Traumatic Shock. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fremont & Wyanoke

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J J Frame, M. D.

3/22 1930 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery

DATE OF BURIAL March 24 1930

20 UNDERTAKER Chas. S. Black 742 W. North Ave

ADDRESS

MAR 24 1930

tion should be carefully supplied. Avoid abbreviations. Write plainly in ink. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55402 — 90 ✓ — E 55402

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Malone

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about 80	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Unknown Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Ireland

14 Informant: Mt Hope Records

(Address): Mt Hope Retreat.

15 Filed APR 24 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 21. 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to March 21, 1930, that I last saw her alive on March 21, 1930 and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Gastro-Enteritis)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia (duration) 20 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William P. Hall, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Mar 24/30

20 UNDERTAKER: Stewart & Mowen Company — ADDRESS: 108-20 Mulberry

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

55403 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55403

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital REGISTERED NO. 10120

CITY OF BALTIMORE, (No. Eaton & Wilkens Ave) 3-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Carana

(a) RESIDENCE No. 3980 Elm Ave city. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred under — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 60 Years Months Days If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typist

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Nume of employer M. H.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER ? Crangle

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Friend Mrs L. K Emens

(Address) 5314 St. George Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1930

17

I HEREBY CERTIFY, That I attended deceased from 2-28-30 1936 to 3-23- 1930.

that I last saw her alive on 3-23 1930

and that death occurred, on the date stated above, at 2 09 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar) following recovery from cardiac decompensation due to chronic myocarditis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St Agnes Hosp

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Paul Cohen, M. D.

, 19 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greens New Cathedral Cemetery DATE OF BURIAL March 25 1930

20 UNDERTAKER Stewart & Co ADDRESS 108 W Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 24 1930

Spec.—1-10-21—M&T—1500 Bks.

E 55404 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 55404**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave (ST.) 28-64 (WARD)

REGISTERED NO. 74-032

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. E Anderson

(a) RESIDENCE NO. 5318 Wesley Ave (ST.) Howard Park (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary F. Anderson

6 DATE OF BIRTH (month, day, and year): Oct 29-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sallie Brenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mary F. Anderson 5318 Wesley Ave

15 Filed MAR 24 1930, 19 .. Registrar: C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-22 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-12, 1930, to 3-22, 1930.

that I last saw him alive on 3-22, 1930,

and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Lung abscess

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): cerebral embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) George Brenner M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Mar 26 1930

UNDERTAKER: Chas F. Maus & Son — ADDRESS: 1180 W. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55405

E 55405

CERTIFICATE OF DEATH.

90

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5410 Hamlett ave St., Ward 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lud Looker Pierce

(a) Residence No. 5410 Hamlett ave St., Ward Hamilton, Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Mar ? 1856.

7-AGE. 74 yrs. ? mos. ? ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Logman in Woods

(b) General nature of industry, business, or establishment in which employed (or employer). Teamster

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS

10-NAME OF FATHER. Geo H. Pierce

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Lois Lukens

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md and

14- (Informant) George H. Pierce

(Address) Hillcrest Road Severna

15- Filed APR 24 1930 192 RWK Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Mar 23-1930

17- I HEREBY CERTIFY, That I attended deceased from Feb 21 1930 to Mar 23 1930

that I last saw h.m alive on Mar 23 1930

and that death occurred, on the date stated above, at 10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

Arterio sclerosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Lee H. Holmes M. D.

March 1930 (Address) Magnolia Md Balto Co

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Monastery Christian Church

DATE OF BURIAL. Mar 26 1930

20-UNDERTAKER. W. T. Archer

ADDRESS Severn Md

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55406

CERTIFICATE OF DEATH.

46 E 55406

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1124 Kenshaw St. (Ward) 46-63

2-FULL NAME Liggins Flournee Abraham,

(a) RESIDENCE NO. 1124 Kenshaw St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Oct 1 - 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	57	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) 0 0 0

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Pa

14 Informant Jas Wallace
(Address) 4124 Kenshaw

15 Filed APR 24 1930, 19.. Registrar E. HAMPSON JONES, M. D. RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 7, 1930, to Mar. 21, 1930, that I last saw h[illegible] alive on Mar. 21, 1930, and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) Indefinite yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Aubrey C. Smoot, M. D.

, 19 (Address) 1013 N. Charles.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 3/25 1930

UNDERTAKER M E Gosnell

ADDRESS 84 W 37

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55407

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 55407

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1004 W. Cross St.) 7-1-29 (WARD)

2—FULL NAME Martha Reibert

(a) RESIDENCE NO. 1004 W. Cross St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 0 ds. — How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (~~write the~~ word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Reibert

6 DATE OF BIRTH (month, day, and year): Mar 5 1852

7 AGE: Years 78 Months 6 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Peter Dittmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Onelepinie Seamm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Henry Stemmerman

(Address) 1004 W. Cross St

15 Filed ... 19 ... Registrar

APR 24 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 22 1930

17

I HEREBY CERTIFY, That I attended deceased from Oct 23 1930 to Mar 22 1930

that I last saw h. alive on Mar 22 1930

and that death occurred, on the date stated above, at 4 00 m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho — Pneumonia.

(duration) yrs. mos. 3 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? No Tests were made Except Urine analysis

(Signed) [illegible] M. D.

1930 (Address) 523 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mar 26 1930
20 UNDERTAKER: D. J. Soesdens Son	ADDRESS: 217 S. Pa

important. See instructions on back of certificates.

Coc.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55408

187 007 E 55408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Maryland General Hospital St. 12-51 Ward)

2-FULL NAME Harry C. Meyls

(a) RESIDENCE NO. 297 W. 31st. St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Meyls

6 DATE OF BIRTH (month, day, and year) September 27, 1883

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
46	5	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Carroll Co. Maryland

PARENTS

10 NAME OF FATHER L. O. Meyls

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice A. Houch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Sarah E. Meyls
(Address) 297 W. 31 st. St.

15 Filed C. HAMPSON JONES M. D. Registrar
APR 24 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows:

Punctured Lung
Fractured 3-4-5-6-7 Ribs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Finksburg, Carroll Co.	March 25-30

20 UNDERTAKER Horace F. Burgee — ADDRESS 3631 Falls Rd.

tion should be carefully supplied. AGE should be stated EXACTLY. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 55409

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55409

CERTIFICATE OF DEATH.

REGISTERED NO. 119

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caulin & Lover ST. 35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Lepenna

(a) RESIDENCE NO. 1008 Lawn St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Lepenna

6 DATE OF BIRTH (month, day, and year) Nov. 20 60

7 AGE: Years 70. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER Joseph Lepenna

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant (Address): John Lepenna 1008 Lawn St

15 Filed — 19 — C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1930

17. I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to March 22, 1930, that I last saw him alive on March 22, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Gangrenous Peri-Proctitis

(duration) yrs. mos 00 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3/3/30

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible] M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: March 1930

20 UNDERTAKER: Weidell & Leppel — ADDRESS: 300 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 1 √ E 55410

E 55410

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. South Baltimore Gen Hospital ST., WARD)

2—FULL NAME Christopher F. Bory

(a) RESIDENCE NO. 1263 Battery ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 4 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Agnes Bory

6 DATE OF BIRTH (month, day, and year) Aug 17 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal

(b) General nature of industry, business, or establishment in which employed (or employer) Employed

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John A Bory

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Bruer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Elgnis Bory

(Address) 1263 Battery Ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22-30

17 I HEREBY CERTIFY, That I attended deceased from 3-17-, 1930, to 3-22, 1930, that I last saw h[illegible] alive on 3-22, 1930 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

& Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical Signs

(Signed) Joseph H. Faulkaitis M. D.

(Address) South Balto Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	March 26 1930

20 UNDERTAKER E. L. Hamm & Evans ADDRESS 38 E. Lex St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55411

CERTIFICATE OF DEATH.

161-001 E 55411

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Hanover ST. 11-24 WARD)

2-FULL NAME John Louis Frazier

(a) RESIDENCE NO. 1304 Hanover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 22 30

7 AGE — Years — Months — Days — If LESS than 1 day 20 hrs. or min. 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) 1304 Hanover St. (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas J. Frazier

11 BIRTHPLACE OF FATHER (city or town) Bellwood, Pa. (State or country)

12 MAIDEN NAME OF MOTHER Bertha M. Wagner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)

14 Informant E. Mather (Address)

15 Filed MAR 24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1930

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to March 23, 1930, that I last saw him alive on March 23, 1930, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth. (7 months)

Undeveloped

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 1215 Hanover.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. ADDRESS MAR 24 1930

UNIVERSITY OF MARYLAND

MEDICAL AND CHIRURGICAL FACULTY

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55412

90 **E 55412**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1814 Harlem St. 16-22 Ward)

2-FULL NAME Jas H. Wheeler

(a) RESIDENCE NO. 1814 Harlem St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora S. Wheeler

6 DATE OF BIRTH (month, day, and year) Jan 26 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	84	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Jas Wheeler

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary L. Wheeler

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Cora S. Wheeler
(Address) 1814 Harlem

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 23 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) [illegible], M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 3/26/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN is very important. See instructions on back of certificate. Exact statement of OCCUPATION of DEATH in plain terms, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Bks.

E 55413 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 55413

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO.....ST. 5-8 WARD)

2-FULL NAME Samuel L. Moore

(a) RESIDENCE NO. 100 N. Front ST., ... WARD .....
(Usual place of abode) (if non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 7-14-1875

7 AGE	Years	Months 8	Days 5	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 60. 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Edwin Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma E. Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Balto. City Hospitals

15 Filed 3-19, 1930 Registrar AAH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-19-30

17 I HEREBY CERTIFY, That I attended deceased from 7-22-29, 19..., to 3-19-30, 19..., that I last saw h... in alive on 3-19-30, 19..., and that death occurred, on the date stated above, at 11:10 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum suspected

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

Arteriosclerosis (duration) 2½ yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W McLean, M. D.

3-19, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery — DATE OF BURIAL 3/25/1930

20 UNDERTAKER Wm Cook — ADDRESS 1219 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks. Jacob W. Gartside ✓

E 55414 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55414

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob W. Gartside

(a) RESIDENCE NO. 1112 Laurens St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 07 8

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Gartside

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Henrietta ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed APR 24 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22-30

17 I HEREBY CERTIFY, That I attended deceased from 12-30-29, 19 ..., to 3-22-30, 19 ...,

that I last saw h.. alive on 3-22-30, 19 ...,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) over 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Senile Dementia (duration) over 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical; Autopsy

(Signed) Warren H. McLean, M. D.

3-24, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 3/26/1930

20 UNDERTAKER Wm Cook 1217 ADDRESS St Paul St

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 55415 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 91 E 55415

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Southern Hospital St. 12-50 (WARD)

2-FULL NAME Harry C Cartwright

(a) RESIDENCE NO. Southern Hospital or House WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Vincentia E. 1844

6 DATE OF BIRTH (month, day, and year) Feb 4,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) England
12 MAIDEN NAME OF MOTHER unknown.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Rennie Hesketh
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct-1- 1929, to March 23, 1930,
that I last saw him alive on March 23, 1930,
and that death occurred, on the date stated above, at 4.30 P. m.
The CAUSE OF DEATH* was as follows: Chron Arteio-Sclerosis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical.

(Signed) H C Haws M. D.
3-23, 1930 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 3/26/30

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

CAUTION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55416

E 55416

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balt. Gen'l Hosp (Ward) 23-5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hester Olivia Jones

(a) RESIDENCE NO. 803 Union Av ST. WARD Hampden

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Fem.~~	W.	Married

5a If married, ~~widowed or divorced~~ ~~HUSBAND of~~ (or) WIFE of Andrew E.

6 DATE OF BIRTH (month, day, and year) 3/12/1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
61	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John M. Snead

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rebecca Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prussia

14 Informant Rel. Hospital

(Address)

15 Filed , 19 RR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24-1930

17 I HEREBY CERTIFY, That I attended deceased from 3-13-1930 to 3-24-1930

that I last saw h~~er~~ alive on 3-23-1930

and that death occurred, on the date stated above, at 5:30 ~~P~~ A.M.

The ~~CAUSE OF DEATH~~* was as follows:

Mesenteric Thrombosis

- Post operative

(duration) - yrs. mos. 4 ds.

CONTRIBUTORY (secondary) Multiple Embolic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-15-30

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) J. V. Castagna, M. D.

, 19 (Address) W. Balto Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's (Hampden) DATE OF BURIAL 3/27/30

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

CAUSE OF DEATH to be plainly written, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55417

CERTIFICATE OF DEATH

90 E 55417

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1337 W Lombard St., 19-29 (Ward)

2-FULL NAME Nellie N. Lamkin

(a) RESIDENCE NO. 1337 W. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14-1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	46	8	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work W.W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Jas. J. Lamkin

11 BIRTRPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Eleanor A. Gallagher

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Howard C. Lamkin
(Address) 1337 W. Lombard

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Brien M. D.

3/24 1930 (Address) 3601 3rd Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park Cem	3/25/1930

20 UNDERTAKER Harry A Weitzke ADDRESS 4101 Edmondson Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PRECISION in OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

2 E 46 55418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 55418

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (STREET) 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Mills

(a) RESIDENCE NO. 2503 W. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 3 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of James 1885

6 DATE OF BIRTH (month, day, and year) Dec 12 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Adam Emig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Eva Wirth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 24 1930 19 C. HAMPSON JONES, (Registrar)

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 22, 1929, to Mar 24, 1930, that I last saw her alive on Mar 24, 1930, and that death occurred, on the date stated above, at 8 00 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of urinary bladder with extension to pelvic tissues, iliac bone rectus muscles, and retro peritoneal lymph glands Pyonephrosis Uremia (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy - Blood Chemistry

(Signed) W. S. Everett, M. D.

3/24, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL 3/26 1930

20 UNDERTAKER Harry N. Nitzke

ADDRESS 4101 Edmondson Ave.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55419

E 55419

CERTIFICATE OF DEATH

90

REGISTERED NO. 96-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 S. Grundy Street ST. (or WARD)

2—FULL NAME Sabatino Demidio Also Sabastino Demeddzo (known as)

(a) RESIDENCE NO. 203 S. Grundy Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lucia Tattoni

6 DATE OF BIRTH (month, day, and year) 3-25-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Agostino Demiddzo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Varie Demiddzo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Arck Demiddzo

(Address) 203 N. Grundy Street

15 Filed APR 24 1930, 19 Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1930

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 22, 1930,

that I last saw h im alive on March 22, 1930

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis (Chronic)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Perongo, M. D.

3. 24. 1930 (Address) 5.14 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cemetery

DATE OF BURIAL: 3/25/ 1930

20 UNDERTAKER: Mary T. Ruth

ADDRESS: 1225 Hanover

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55420 ✓ E 55420

CERTIFICATE OF DEATH

152

1—PLACE OF DEATH Woman's Hospital.. REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 12-20 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie Rivers Byrd.

(a) RESIDENCE NO. 118 W. Lafayette ST., ... WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. ✓ mos. ✓ ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Byrd.

6 DATE OF BIRTH (month, day, and year) Sept 11, 1839.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
90 years	6 mo.	13 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 027

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Nashville
(State or country) Tenn.

PARENTS

10 NAME OF FATHER Robert Jones Rivers

11 BIRTHPLACE OF FATHER (city or town) ✓
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Susan Cheatham

13 BIRTHPLACE OF MOTHER (city or town) Nashville
(State or country) Tenn.

14 Informant Mary Armistead Byrd.
(Address) 118 W. Lafayette St

15 Filed APR 24 1930, 19 ARM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1930, to March 24, 1930 that I last saw h.e.r alive on March 24, 1930 and that death occurred, on the date stated above, at 10 41 a. m.

The CAUSE OF DEATH* was as follows:

Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Carbuncle on back (non diabetic) (duration) ✓ yrs. ✓ mos. 14 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Rudolph J. Schorke, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Manchester Va	March 26, 1930
20 UNDERTAKER John O Mitchell & Sons	ADDRESS 400 Eutaw Place

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

(Devilbiss)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55421

E 55421

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (Co.) 1708 N Port St. ST., 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur D. Develbiss

(a) RESIDENCE NO. 1708 N Port St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced, HUSBAND of (or) WIFE of: Frederick A Develbiss

6 DATE OF BIRTH (month, day and year): June 12 1878

7 AGE: Years 51 | Months 9 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible] 05

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: C. Schultz & Co

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Milton Develbiss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Amanda Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Frederick A. Develbiss

(Address) 1708 N. Port St.

15 Filed ..... 19 ..... Per ..... Registrar

R 3-24-1930 C. HAMPSON GIBBS, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23 1930

17 I HEREBY CERTIFY, That I attended deceased from March 13 1930 to March 23 1930

that I last saw h[illegible] alive on March 22 1930

and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert E. Bunting, M. D.

3/24/30 (Address) 2025 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 3/24/30

20 UNDERTAKER: Joseph Ahrens

ADDRESS: 221 Bway

Important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55422

CERTIFICATE OF DEATH

101-001

E 55422

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 5312 Catalpha Rd 27-45 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Ryan

(a) RESIDENCE NO. 5312 Catalpha Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Ryan

6 DATE OF BIRTH (month, day, and year) August 5 1869

7 AGE Years 60 Months 7 Days 7 IF LESS than 1 day ... hrs. or ... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Moulder

(c) Name of employer

9 BIRTHPLACE (city or town) Mt Washington (State or country) Md

PARENTS

10 NAME OF FATHER James Ryan

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Cora Ryan (Address) 5312 Catalpha Rd

15 Filed C. HAMPSON JONES M. D. Registrar

R 24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to March 22, 1930, that I last saw him alive on March 22, 1930, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) C. H. Jones M. D.

3-28, 1930 (Address) 4218 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — Date of Burial March 25 1930

20 UNDERTAKER John O Mitchell & Sons — ADDRESS 1910 Eutaw Place

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

(Carrie Horsey)

E 55423 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55423

46

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balt City Hosp. (St.) 3-4 (WARD)

2-FULL NAME Virginia Horsey Carrie [Carrie Horsey]

(a) RESIDENCE NO. 403 N. Carlton ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 12-1-1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Cummins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed MAR 24 1930, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23-30

17 I HEREBY CERTIFY, That I attended deceased from 7-10, 1929, to 3-23, 1930,

that I last saw h[illegible] alive on 3-23, 1930,

and that death occurred, on the date stated above, at 1 50 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri

(duration) Unknown mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lee Pumphrey, M. D.

3-24 1930 (Address) Balt City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL 3/24/30

UNDERTAKER Mary T. Ruth ADDRESS 1735 Harford

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55424

CERTIFICATE OF DEATH

88 E 55424

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1911 Longwood ST. 15-67 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lenore Hall Harper

(a) RESIDENCE NO. 1911 Longwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lyrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~
F.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Robert W. Harper

11 BIRTHPLACE OF FATHER (city or town) Chapel
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Turner

13 BIRTHPLACE OF MOTHER (city or town) Ala
(State or country) Ala

14 Informant Robert W. Harper
(Address) 1911 Longwood St.

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1930, to March 23, 1930, that I last saw her alive on March 24, 1930 and that death occurred, on the date stated above, at 5-15 A. m.

The CAUSE OF DEATH* was as follows:

Malignant Endocarditis

(duration) ....yrs. ....mos. 2-1 ds.

CONTRIBUTORY (Secondary) Chorea,

(doration) ....yrs. 2 mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj O McCeny, M. D.

3/24/30 (Address) 6008 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemt

DATE OF BURIAL Mar 25-1930

20 UNDERTAKER Reitzammel Gore

ADDRESS 1723 W Lafayette ave

important. See instructions on back of certificates.

APR 24 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55425

CERTIFICATE OF DEATH

74-001 E 55425

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1034 Poplar Grove ST. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joanna Bishop

(a) RESIDENCE NO. 1034 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Bishop

6 DATE OF BIRTH (month, day, and year) Nov. 2, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Grove Haight

11 BIRTHPLACE OF FATHER (city or town)

(State or country) United States

12 MAIDEN NAME OF MOTHER Joanna Peters

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) United States

14 Informant Mrs. Joanna B. Richards

(Address) 1034 Poplar Grove St.

15 Filed 3/24 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 10, 1926, to March 23, 1930, that I last saw her alive on March 23, 1930 and that death occurred, on the date stated above, at 6.35 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Left side

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Exam.

(Signed) John A. Whelan, M. D.

3/24, 1930 (Address) 1219 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL Mar. 25, 30

20 UNDERTAKER Fred D. Cook

ADDRESS 1003 West Baltimore St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55426

CERTIFICATE OF DEATH

101-001

E 55426

1—PLACE OF DEATH

REGISTERED NO. 2129

CITY OF BALTIMORE: (No. 760 Ramsey St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Murray

(a) RESIDENCE NO. 760 Ramsey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bartlett Hayward Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER James Murray

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann McElroy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Margaret Murray
(Address) 760 Ramsey St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15, 1930, to Mar 24, 1930, that I last saw h 1m alive on Mar. 24, 1930 and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation,

(duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Etc.

(Signed) Thos. Norton, M. D.

3/24, 1930 (Address) 888 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Mar. 27 1930
20 UNDERTAKER	ADDRESS
[illegible] Cook	1003 West Baltimore St.

important. See instructions on back of certificates.

C. HAWSON JONES, M.D.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55427

CERTIFICATE OF DEATH.

34 E 55427

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 14-27 WARD)

2-FULL NAME Wm. H. Butler

(a) RESIDENCE NO. 214 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14-1904

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
25	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook & Officer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Perry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed MAR 25 1930 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24-30

17 I HEREBY CERTIFY, That I attended deceased from 2-17, 1930, to 3-24, 1930, that I last saw h[illegible] alive on 3-24, 1930, and that death occurred, on the date stated above, at 5 40 a. m.

The CAUSE OF DEATH* was as follows:

Pott's disease lumbar region

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. H. Pumphrey, M. D.

3-24 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mount Lion March 27 1930

20 UNDERTAKER ADDRESS

Joseph A Lucy 409 N Monroe St

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55428 ✓ E 55428

CERTIFICATE OF DEATH.

31

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 223 N. Parrish ST. 19-27 WARD)

2-FULL NAME Annie Haymen Williams

(a) RESIDENCE NO. 223 N. Parish ST. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Haymen

6 DATE OF BIRTH (month, day, and year): July 5, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	36	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Laurel Md.

PARENTS

10 NAME OF FATHER: Robert Hebron

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundel Co., Md.

12 MAIDEN NAME OF MOTHER: Jemima Junior

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co., Md.

14 Informant: Jennie Brooks
(Address): 515 N. Parish St.

Filed MAR 25 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1930, to Mar 20, 1930, that I last saw her alive on Mar; 19, 1930 and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Prob. Tubercular

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Exposure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? NO Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel maryland

DATE OF BURIAL: March 25 30

20 UNDERTAKER: Joseph A Lively

ADDRESS: 409 N Main St

Spec.—8-16-29—L. F. S.—100 Bks.

E 55429

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 55429

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosie West.

(a) RESIDENCE NO. 1400 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James West

6 DATE OF BIRTH (month, day, and year) Remembers

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rosie Sims

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Maggie Keller

(Address) 1400 Madison Ave

Filed APR 25 1930 WILLIAM J. JONES, M. D. Registrar

Patt

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/30

17 I HEREBY CERTIFY, That I attended deceased from 3/11/30, 19..., to 3/23, 19..., that I last saw h.. alive on 3/23, 1930 and that death occurred, on the date stated above, at 11 20 a. m.

The CAUSE OF DEATH* was as follows:

Multiple myomata uteri
Cardio Renal disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes No Date of 3/18/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Bernard Harris, M. D.

3/23/30 Address Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harbarton Wks	3-26 1930
20 UNDERTAKER accomac. Co	ADDRESS 1027 Madison
John H. Jenkins	

OF DEATH be plain (terms so that it may be properly classified). important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55430 — 129 — E 55430

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~Hanover Hosp.~~ ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thos. Edwin Sanford

(a) RESIDENCE NO. 1914 W. North Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha E. Sanford

6 DATE OF BIRTH (month, day, and year) May 9 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Rock Race

(State or country) Md

PARENTS

10 NAME OF FATHER John W. Sanford

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Emeline Thrift

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Emma E. Sanford

(Address) 1914 W North ave

....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/30

17 I HEREBY CERTIFY, That I attended deceased from 3/19, 1930, to 3/23, 1930,

that I last saw him alive on 3/23, 1930,

and that death occurred, on the date stated above, at 5:40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic hypertension heart disease & chr nephritis

unknown (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) ....yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What (est confirmed diagnosis? Clinical.

(Signed) Henry D. Wessit, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL March 25 1930

20 UNDERTAKER H. Friedenwald Sons — ADDRESS N. Y. Pa.

MAR 25 1930 — C. HAMPSON JONES, M. D. — Registrar

OF DEATH in plain terms, so that it may be properly classified. Entry important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55431

REGISTERED NO. E 55431

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2602 (ST.) Rogers Ave (WARD) 27-55

2-FULL NAME Davis Baker

(a) RESIDENCE NO. 2602 Rogers Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Purnell Baker

6 DATE OF BIRTH (month, day, and year): April 12 1855

7 AGE: Years 74 | Months 11 | Days 12 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co.

PARENTS

10 NAME OF FATHER: Charles A. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Hannah Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Mrs Deborah Baker 2602 Rogers Ave

15 [illegible] 19 H. [illegible] JONES, M. D. Registrar

APR 25 1930 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 27. 1930

17 I HEREBY CERTIFY, That I attended deceased from February 22 30 to March 27. 1930.

that I last saw h[illegible] alive on March 27. 1930,

and that death occurred, on the date stated above, at 3-10 P. m.

The CAUSE OF DEATH* was as follows:

Abscess of left hip. Pulmonary Edema (Acute)

(duration) yrs. 2+ mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) yrs + mos. ds.

18 Where was disease contracted if not at place of death? Fullerton Md.

Did an operation precede death? Yes Date of Feb-25-1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gibson Porter, M. D.

3/24/1930 (Address) 7822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge DATE OF BURIAL: Mar 31, 30

20 UNDERTAKER: A. S. Marshall ADDRESS: 353 Dallas Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55432

CERTIFICATE OF DEATH.

E 55432

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 W. Conway ST. 72-30 WARD)

2-FULL NAME Francis Bates

(a) RESIDENCE NO. 440 W. Conway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Bates

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Selma (State or country) Ala.

PARENTS

10 NAME OF FATHER Smith Parke

11 BIRTHPLACE OF FATHER (city or town) Selma, (State or country) Ala.

12 MAIDEN NAME OF MOTHER Sallie Gosby

13 BIRTHPLACE OF MOTHER (city or town) Selma (State or country) Ala.

14 Informant Henry Parke

(Address) 440 W. Conway St.

Filed MAR 25 1930, 19 HARRY M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 29, to Mar 23, 19 30, that I last saw her alive on Mar. 20, 19 30, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinomita of Uterus.

(duration) yrs. 8 mo 20 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical and microscopic exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 E. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cadvery Cem

DATE OF BURIAL 3-25 1930

20 UNDERTAKER Lonnie Elston

ADDRESS 916 Pa ave

CAUSE OF DEATH. See instructions on back of certificates. TION is very important

Spec. 1-10-21—M&T 1500 Blks.

James L M Landin

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55433

CERTIFICATE OF DEATH.

90

E 55433

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1747 E North ave ST. 15-21 WARD)

2-FULL NAME James L M. Landin

(a) RESIDENCE NO. 1747 E North av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Idale Landin

6 DATE OF BIRTH (month, day, and year) May 14 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	61	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James H Landin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co Md

12 MAIDEN NAME OF MOTHER Mary Madell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ida L Landin

(Address) 1747 E North ave

R 25 1930

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/30

17 I HEREBY CERTIFY, That I attended deceased from ....., 1929 ..... to 3/23 ..... 1930 .....

that I last saw him alive on 3/22 1930

and that death occurred, on the date stated above, at 1:45 a m.

The CAUSE OF DEATH* was as follows:

Organic Vascular Heart Disease

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Alg S Gage M. D.

3/24/30 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem.

DATE OF BURIAL 3/25/1930

20 UNDERTAKER Robt J Turner

ADDRESS 1442 N Broadway

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Bks.

E 55434

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55434

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 21-29 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Nicol

(a) RESIDENCE NO. 721 Ramsey st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 8, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookbinder

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Nicol

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susie Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed MAR 25 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1930, to March 24, 1930, that I last saw her alive on March 24, 1930, and that death occurred, on the date stated above, at 4.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas. Ghrmod Jones M.D.

3-25 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampden St. Mary Cem.

DATE OF BURIAL Mar 27th 1930

20 UNDERTAKER Geo. Lambert & Son.

ADDRESS 520 Lyndhurst St.

CAUSE OF DEATH to be plainly written, and the certificate signed by physician. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55435

5/E 55435

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 10-14 WARD)

2-FULL NAME Anna Shanahan

(a) RESIDENCE NO. 1115 Greenmount Ave. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 10 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Shanahan

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Pierce

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant John Shanahan
(Address) 1115 Greenmount

15 Filed MAR 25 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/22, 1930, to 3/23, 1930, that I last saw her alive on 3/23, 1930, and that death occurred, on the date stated above, at 11 50 A.M.

The CAUSE OF DEATH* was as follows:

Rheumatic cardio-Valvular disease - Mitral stenosis & insufficiency
Rheumatic pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Rheumatic fever
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopical Exam.

(Signed) L. A. Gibbs M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 3/26 1930

20 UNDERTAKER Mary A. Gawthrop

ADDRESS 2839 Pay

mation should be carefully supplied. AGE should be stated in YEARS. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-12-25—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55436

CERTIFICATE OF DEATH.

88 E 55436

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 W. Hamburg Street, ST. 73-31 WARD)

2-FULL NAME Eckhardt Schmidt,

(a) RESIDENCE NO. 15 W. Hamburg St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 61 mos. ds. How long in U. S., if of foreign birth? 61 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Schmidt

6 DATE OF BIRTH (month, day, and year) Nov 8th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Germy Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Robert Schmidt (Address) 206 E Fort Ave

Filed MAR 25 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1930

17

I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to March 22, 1930,

that I last saw him alive on March 21, 1930

and that death occurred, on the date stated above, at 10 P.m

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of - - - -

Was there an autopsy? no

What test confirmed diagnosis? physical findings

(Signed) Harry Heibel M. D.

3/25 1930 (Address) 1224-1226 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL March 26 1930

20 UNDERTAKER E Schlomawbon

ADDRESS 1039 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

235-252

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55437

CERTIFICATE OF DEATH

E 55437

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-13 WARD)

2—FULL NAME Nannie Winn

(a) RESIDENCE NO. 1805 E Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	B.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard WINN

6 DATE OF BIRTH (month, day, and year) Sept. 15 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Keyesville (State or country) Va

PARENTS

10 NAME OF FATHER John Wordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emma Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

Filed MAR 25 1930, 19 C. HAMPTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March-23-30

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1930, to March 23, 1930, that I last saw her alive on March 23, 1930 and that death occurred, on the date stated above, at 330 A m.

The CAUSE OF DEATH* was as follows:

HAEMORRHAGE

Shock, surgical.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) PLACENTA PRAEVIA

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of MAR. 22/30

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) R. Gordon Douglas M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL Mar. 26 1930

UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1725 Washington Ave

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55438

CERTIFICATE OF DEATH

45 E 55438

1—PLACE OF DEATH South Balto. Gen. Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 5 ST., 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna Disney

(a) RESIDENCE NO. 615 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ralph Disney

6 DATE OF BIRTH (month, day, and year) Mar. 5, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ralph Disney

(Address) 615 W. Mulberry St.

15 Filed APR 25 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-21-30

17 I HEREBY CERTIFY, That I attended deceased from 2-10-30, 19..., to 3-21-30, 19..., that I last saw h[illegible] alive on 3-21-30, 19..., and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Descending Colon and Sigmoid

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia - myocardial failure (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of 2-22-30

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Francis A. Fuller, M. D.

, 19 (Address) So. Balt. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon cemetery	Mar 25 1930
20 UNDERTAKER Mrs. R. A. Elbert	ADDRESS 1725 Eastlundale

OF DEATH in plain terms, so that it may be easily understood. important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55439

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55439

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST 7331 WARD)

2-FULL NAME Michael Gardner.

(a) RESIDENCE NO. 135 E. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 9, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER B. Gardner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER G. Meier

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Records.

(Address) BALTIMORE CITY HOSPITALS

Filed MAR 25 1930 C. H. WILSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to March 23, 1930, that I last saw h in alive on March 23, 1930, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic.

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation (duration) yrs. mos. 2 hrs.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surmise.

(Signed) Paul Padget, M. D.

3-23 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 3-26 1930

UNDERTAKER J. B. Harle

ADDRESS 115 E West St

INSTRUCTION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

234780

E 55440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101 00

E 55440

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alfred Williams

(a) RESIDENCE NO. 1115 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Car

PARENTS

10 NAME OF FATHER Mack Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Car

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 25 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24-30

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1930, to March 24, 1930, that I last saw h alive on March 24, 1930 and that death occurred, on the date stated above, at 503 A m.

The CAUSE OF DEATH* was as follows:

Uremia from obstruction to urinary tract from post Urethritis following lobar pneumonia

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/22/30

Was there an autopsy? Yes

What test confirmed diagnosis? Blood urea

(Signed) J. A. Smith, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Lem	3/27 19 30
20 UNDERTAKER	ADDRESS
Robert F Williams	1515 N Eden St

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55441

CERTIFICATE OF DEATH.

90 E 55441

REGISTERED NO.

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... St., 69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Thompson

(a) RESIDENCE NO. 1750 Mullikin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Louis Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Price.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

Date MAR 25 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to March 20, 1930, that I last saw him alive on March 20, 1930, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute.

More Than (duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

UNKNOWN (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padgett. M. D.

3-22, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	3/25 1930
20 UNDERTAKER	ADDRESS
Robert Mikesell	5 m Eldon

CAUSE OF DEATH must be given in plain terms. See instructions on back of certificates. TION is very important

Spec.—2-29-28—L. F. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55442 (1930) ✓ E 55442

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 625 Lanvale ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fanny Davis

(a) RESIDENCE NO. 625 Lanvale ST. WARD

(Usual place of abode)

(If non-resident give city or town and State) New York

Length of residence in city or town where death occurred yrs. mos. 36 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Levy Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lena Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Fannie Dorsey

(Address) 625 Lanvale St

15 Filed MAR 25 1930, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23/30

17 I HEREBY CERTIFY, That I attended deceased from Dec 9, 1929 to Mar 23, 1930

that I last saw him alive on Mar. 23, 1930

and that death occurred, on the date stated above, at 9.00 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) David E. Brandt M. D.

3/25, 1930 (Address) 706 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid

DATE OF BURIAL 3/26/30

20 UNDERTAKER Wm. Geo. H. Holland

ADDRESS 1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55443

CERTIFICATE OF DEATH

X 101-001

E 55443

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 416 Robert ST. 44-20 WARD)

2—FULL NAME Lucy Gregory

(a) RESIDENCE NO. 416 Robert ST., WARD 9a
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Gregory

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 52?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Co. Va.

PARENTS

10 NAME OF FATHER Wm. Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Gloucester Co. Va.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Gloucester Co. Va.

14 Informant Wm. Gregory

(Address) 416 Robert St

15 Filed ..... 19..... HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-30

17 I HEREBY CERTIFY, That I attended deceased from March 18. 1930. to March 27. 1930.

that I last saw h.e alive on March 23, 1930

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Lab.

(Signed) A Marcus Williams, M. D.

3-27, 1930 (Address) 1830 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Point, Va.

DATE OF BURIAL 3/25/1930

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1631 Druid Hill

mation should be carefully supplied. Also answer all questions OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 5 1930

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55444

CERTIFICATE OF DEATH

E 55444

73

1-PLACE OF DEATH Germain

REGISTERED NO.

City of BALTIMORE: (No. Barclay & 22nd St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Lippy

(a) RESIDENCE NO. Barclay & 22nd St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of Joseph H Lippy

6 DATE OF BIRTH (month, day, and year): April 23 - 1849

7 AGE — Years: 80 Months: 11 Days: 1 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Jonas Deal

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rhoda Bush

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Mrs Jos H Lippy

(Address): Barclay & 22nd

15 Filed MAR 25 1930 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1 1929 to Mar. 24 1930

that I last saw her alive on Mar. 24 1930

and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Paralysis of left glosso Pharyngeal nerves

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) G. H. D. Lippy, M. D.

3-25-1930 (Address) 432 S. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls, Balto Co — Date of Burial: Mar 27 1930

20 UNDERTAKER: Edw C Tipton — ADDRESS: Hampstead Md

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE MUST BE FILLED OUT IN FULL. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55445

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55445

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2210 N. Charles ST. 12-51 WARD)

2-FULL NAME Brigitta Cramer

(a) RESIDENCE NO. 2210 N. Charles ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., if of foreign birth? 80 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 84 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Anton Stelter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Agnes Sauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. F. Joseph Kuper

(Address) 2210 N. Charles

15 Filed MAR 25 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAR 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 14, 1930, to March 24, 1930,

that I last saw her alive on March 23 1930,

and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows: Cerebral Sclerosis - Myocarditis -

Chr Nephritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual means

(Signed) F. J. Kuper, M. D.

(Address) 110 E Northave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: March 26 1930

20 UNDERTAKER: Henry Hoech Sons Inc. — ADDRESS: 1301 Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks. Charles Althoff

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55446

CERTIFICATE OF DEATH.

74-001 E 55446

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 1-3 ST., WARD)

2-FULL NAME Charles Althoff

(a) RESIDENCE NO. 513 S. Chester St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of –

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Emmittsburg (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Althoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Worthen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ....., 19.. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23-30

17 I HEREBY CERTIFY, That I attended deceased from 3-13-30, 19.., to 3-23-30, 19..,

that I last saw him alive on 3-23-30, 19..,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of –

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean M. D.

3-24, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL March 26 30

20 UNDERTAKER Ehrenworth Son

ADDRESS 367 Chestnut St

CAUSE OF DEATH to be plainly written, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55447

CERTIFICATE OF DEATH.

REGISTERED NO. E 55447

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (ST.) (WARD)

2-FULL NAME Mr. William Neal

(a) RESIDENCE NO. 2638 W. North Ave. (ST.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Neal

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer gdn

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Wm. Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Hodgson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Harry Farrell

(Address)

15 Filed ..... 19 ..... Registrar

MAR 25 1930 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1930

17

I HEREBY CERTIFY, That I attended deceased from March 21, 1930 to March 23, 1930.

that I last saw him alive on March 23, 1930

and that death occurred, on the date stated above, at 8.35 p. m.

The CAUSE OF DEATH* was as follows:

Chronic glomerulo-nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory.

(Signed) S. A. Alessi, M. D.

19 (Address) Westbalto Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Hanover

DATE OF BURIAL: Mar 27 1930

20 UNDERTAKER: Chas. W. Thompson

ADDRESS: 3615 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55448

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

REGISTERED NO. E 55448

1—PLACE OF DEATH Balto City Hospts.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto Md. ST., 13-51 WARD)

2—FULL NAME Catherine Carlucci

(a) RESIDENCE NO. 211 Union Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Separated

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (3)

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) Balto City Hosp

15 [illegible] HAMPTON JONES, M. D. Registrar

MAR 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24-30

17 I HEREBY CERTIFY, That I attended deceased from 3-3-, 1930, to 3-24-, 1930, that I last saw h[illegible] alive on 3-24-, 1930 and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Broncho Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry F. Dowdall, M. D.

3/25, 1930 (Address) Baltimore City Hospts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL March 27 1930

20 UNDERTAKER [illegible]

ADDRESS [illegible]

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that they may be

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55449

CERTIFICATE OF DEATH

90 E 55449

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1505 E Pratt ST. 3-4 WARD)

2—FULL NAME Elva Robinson

(a) RESIDENCE NO. 1505 E Pratt ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed or divorced HUSBAND of (or) WIFE of: Emmo Robinson

6 DATE OF BIRTH (month, day, and year): Feb 9 1894

7 AGE: Years 36 | Months 10 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dantes

(b) General nature of industry, business, or establishment in which employed (or employer): of

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Nicholas Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary Cooper

(Address): 1505 E Pratt St

15 Filed ..., 19... Registrar: C. HAMPSON JONES, M. D.

AR 25 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 21-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to Mar 21, 1930

that I last saw her alive on Mar 20, 1930

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Chronic Valvular Disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Lewis J. Allen M. D.

Mar 21, 1930 (Address) 508 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery

DATE OF BURIAL: march 24, 1930

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 orleans st

OF DEATH in plain terms, so that it may be properly classified. Items 1 to 13 are important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

N. B.—WHITE PLAINLY, WITH INDELIBLE INK. All the questions should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55450

E 55450

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 302 N. Spring St St. 5-9 Ward)

2-FULL NAME Catherine Bennett

(a) RESIDENCE NO. 302 N. Spring St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Bennett

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's Co., Md.
(State or country)

PARENTS

10 NAME OF FATHER Perry Gant

11 BIRTHPLACE OF FATHER (city or town)
(State or country) St. Mary's Co., Md.

12 MAIDEN NAME OF MOTHER Winnie Hopewell

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's Co., Md.
(State or country)

14 Informant Wendall Dipple
(Address) 300 S. Eden St

15 Filed MAR 25 1930 19 H. LAMPERT JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no (Dr. Remsen Hopkins

What test confirmed diagnosis? Information from

(Signed) , M. D.

3/25/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Michael's St

DATE OF BURIAL March 26 1930

20 UNDERTAKER Richard Thomas Richard Tomas.

ADDRESS Valley St Valley St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55451

CERTIFICATE OF DEATH

90

REGISTERED NO. E 55451

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28-63 WARD)

2—FULL NAME J. Murray Dill

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 1 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 58 | Months Unknown | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Unknown Penna.

PARENTS

10 NAME OF FATHER: Adolph Dill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lebanon Penna.

12 MAIDEN NAME OF MOTHER: Eliz. Wiedman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lebanon Penna.

14 Informant: Mt Hope Retreat
(Address): Mt Hope Retreat

15 Filed MAR 25 1930, 19 [illegible] Registrar

OF DEATH in plain terms, so that it may be properly classified. Early statement of occupation is important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924 to March 25, 1930, that I last saw h[illegible] alive on March 25, 1930 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(Cardiac Insufficiency) (Sudden)
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senile Psychosis
(duration) 33 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Fiel M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va. — DATE OF BURIAL: Mar 26 1930

20 UNDERTAKER: Henry H Jenkins Sons — ADDRESS: 20 Mulberry & Orchard Sts

MAR 25 1930 HARRISON JONES, M. D.

HEALTH DEPARTMENT—CITY OF BALTIMORE 40 E 55452

E 55452

CERTIFICATE OF DEATH

REGISTERED NO. 15-65

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3731 Nortonia Road ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sula Boone Roussel

(a) RESIDENCE NO. 3731 Nortonia Road ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter S. Roussel

6 DATE OF BIRTH (month, day, and year) --------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mississippi

10 NAME OF FATHER F. M. Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mississippi

12 MAIDEN NAME OF MOTHER ------ Curlee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not obtainable

Informant Walter S. Roussel

(Address) 3731 Nortonia Road

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/30

17 I HEREBY CERTIFY, That I attended deceased fr
March 1 1930, to March 24 1930
that I last saw h alive on March 24 1930
and that death occurred, on the date stated above, at 1:30 a

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum
& Bladder causing Recto-
Vaginal Fistulae.

(duration) — yrs. 3 mos. —

CONTRIBUTORY (Secondary) Hysterectomy for Carcinoma 7 July 1929
(duration) 8 months

18 Where was disease contracted if not at place of death? Hysterectomy

Did an operation precede death? Yes Date of Feb 1929

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Jefferis Buck M.D.

3/25 1930 (Address) 5 Club Road

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 3/26 19

20 UNDERTAKER Henry U. Means & Son

ADDRESS 805 N. Gay

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55453

100-001

E 5545

CERTIFICATE OF DEATH.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 513 E. 28th st (ST.) 9-46 (WARD)

REGISTERED NO. _____ (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen P. Bonhage

(a) RESIDENCE NO. 513 E 28th st ST., _____ WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (~~HUSBAND~~ of (or) WIFE of) Henry Bonhage

6 DATE OF BIRTH (month, day, and year) 5/28/1846

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	83	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home 037

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Elsie M Reed

(Address) 5209 York Rd

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/30

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1930, to March 24, 1930, that I last saw her alive on March 24, 1930, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. _____ mos. 3 ds.

CONTRIBUTORY (Secondary) Glaucoma Acute

Bronchitis (duration) yrs. _____ mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of _____

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. J. Costello, M. D.

, 19 (Address) 335 E 31st

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 3/26/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

MAR 26 1930 HEALTH DEPARTMENT

Cor.—10-10-29—A Co.—100 Bks.

Cancer Bladder

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55454

CERTIFICATE OF DEATH

185 E 55454

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 8-45 Ward)

2-FULL NAME Mary Labby

(a) RESIDENCE NO. 1665 Clifton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Jas B Labby

6 DATE OF BIRTH (month, day, and year) 4/22/1864

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
65	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer Self

9 BIRTHPLACE (city or town) .....
(State or country) Phila. Pa.

PARENTS

10 NAME OF FATHER John Willis

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Lewis B Labby Sr
(Address) 1665 Clifton Ave

15 Filed MAR 26 1930 19.. WILLIAM J. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:*
Fell from Chair in her home
Fracture of Left hip

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia
(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? History

3/24/30 (Signed) G C Stades M. D.
19 (Address) 1730 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 3/26/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 55455

CERTIFICATE OF DEATH

E 55455

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 S. Howard ST. 12-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Dimarco

(a) RESIDENCE NO. 228 S. Howard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) abt 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Francisco Dimarco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Leris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Annie Dimarco

(Address) 228 S. Howard St.

15 MAR 26 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 19, 1930, to Mar. 24, 1930, that I last saw him alive on Mar. 23, 1930 and that death occurred, on the date stated above, at 1. a m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) 6 yrs. mos. 1 ds.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm C Black M. D.

19 (Address) 719 Med Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 3/26/30 19

20 UNDERTAKER J. J. Faherty & Sons

ADDRESS 1318 Light

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55456

CERTIFICATE OF DEATH. + 129

E 55456

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave (Ward) 20-19

2-FULL NAME Mrs Agnes Schroen

(a) RESIDENCE NO. 634 Soleraine Rd Caton WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of George J. Schroen

6 DATE OF BIRTH (month, day, and year) June 20. 1860

7 AGE 69 Years 9 Months 1 Days

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home 0 31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Rawlings

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Md.

14 Informant George Schroen

(Address) 634 Soleraine Rd Caton

15 Filed MAR 26 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-6-30. 1930 to 3-23- 1930, that I last saw her alive on 3-23- 1930, and that death occurred, on the date stated above, at 12 M. p. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Nephritis Chronic Interstitial

Myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Coronary Embolus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Eliot W. Johnson M. D.

, 19 (Address) 3326 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Mar 27 1930

20 UNDERTAKER Elmer W. Conklin ADDRESS 624 E. Eager St.

Please Answer Questions Carefully Supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55457. HEALTH DEPARTMENT—CITY OF BALTIMORE E 55457.

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 25-77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Konchun

(a) RESIDENCE NO. 1520 Cypress st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patronella ?

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Hospital Records (Address)

15 Filed APR 26 1930. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to March 24, 1930, that I last saw him alive on March 24, 1930, and that death occurred, on the date stated above, at 7.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos Ghmolek M. D.

3-25 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A.A.C. DATE OF BURIAL: March 27. 1930

20 UNDERTAKER: John Grebliauckas F.D. ADDRESS: 423 S Paca St.

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55458

CERTIFICATE OF DEATH

171 E 55458

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2204 Garrison St.) (Ward 15-61)

2-FULL NAME Harry D Shoemaker

(a) RESIDENCE NO. 2204 Garrison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura.

6 DATE OF BIRTH (month, day and year) 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
About	76			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 066
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Geo. Schumpert
(Address) 2 Saint Paul Place

15 Filed MAR 26 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Suicide (Razor)
Lacerated Throat
(duration) yrs. London mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Blanchard M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 3/27/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55459

CERTIFICATE OF DEATH

17 ✓ E 55459

1-PLACE OF DEATH

City of Baltimore: (No. 2204 Garrison Av. 15-61 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura Appleweiler

(a) RESIDENCE No. 2204 Garrison Av. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry.

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
about	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John A. Caldwell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Williams

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Geo. Schuster
(Address) Calvert Bank 1300

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ... death by ... (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH was as follows: Suicide (Razor, Lacerated Throat

... (duration) ... yrs. Sudden

CONTRIBUTORY ...
(Secondary)

... (duration) ... yrs. ... mos. ... ds.

Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 3/27/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55460

CERTIFICATE OF DEATH

E 55460

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland Penitentiary Hosp. ST., (WARD)

REGISTERED NO. 3103

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Bailey #2.

(a) RESIDENCE NO. 826 West Lee ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella West Bailey

6 DATE OF BIRTH (month, day, and year) 1885? Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer Contractors?

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Roxy Ewell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown Virginia

14 Informant Estella Bailey (Wife)

(Address) 826 W. Lee St

15 Filed APR 26 1930 C. PAUL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 4, 1930, to March 25, 1930,

that I last saw him alive on March 25, 1930

and that death occurred, on the date stated above, at 12.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Appearance & Cause

(Signed) Chas Wm Edmunds, M. D.

, 19 (Address) 2746 Alameda Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion C

DATE OF BURIAL Mar 26 1930

20 UNDERTAKER L. L. Brown & Son

ADDRESS 1054 W. Monty

IN DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55461

100-001

E 55461

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 6-11 WARD)

2-FULL NAME Myrtle Rollinson

(a) RESIDENCE NO. 205 W. Lenwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leroy Rollinson

6 DATE OF BIRTH (month, day, and year) Sept 23/96

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Mary land

PARENTS

10 NAME OF FATHER Frank Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elsie Franks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23-30

17 I HEREBY CERTIFY, That I attended deceased from 2-24, 1930, to 3-23, 1930, that I last saw h[illegible] alive on 3-23, 1930, and that death occurred, on the date stated above, at 3-30 P.m.

The CAUSE OF DEATH* was as follows:

Right hydronephrosis and Pyelonephritis

(duration) Unknown mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. H. Crumpler, M. D.

3-29 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 3/26 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

TION is very important. See instructions on back of certificates.

APR 28 1930 [illegible]

Spec.—1-30—M. & T.—250 Blks.

E 55462

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55462

38

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. ..... ST. 6-9 WARD)

2-FULL NAME William E. Haynie

(a) RESIDENCE NO. 1507 Jefferson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Martha Haynie

6 DATE OF BIRTH (month, day, and year) ... 1879

7 AGE	Years	Months	Days	If LESS than 1 day.... hrs. or.... min.
	60(?)	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor.

(b) General nature of industry, business, or establishment in which employed (or employer) ... 0&6

(c) Name of employer unknown.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Henry Haynie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Emily Evans.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant ..... BALTIMORE CITY HOSPITALS
(Address)

Filed MAR 26 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1930.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1930, to March 22, 1930, that I last saw him alive on March 22, 1930, and that death occurred, on the date stated above, at 6:45 P.m.

The CAUSE OF DEATH* was as follows:

Syphilis of central nervous system.

Morbus (duration) ... yrs. 17 mos ... ds.

CONTRIBUTORY (Secondary) Hemorrhage into Cerebrum (duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Wasserman; exam.

(Signed) Paul Padget M. D.

3-23-1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lillian Va.	Mar. 27, 1930
20 UNDERTAKER Chas. H. Johnson 4671	ADDRESS Caroline St.

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

55463

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 55463

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1628 E. Oliver St. 8-17 Ward)

2-FULL NAME Josephine F. Braun

(a) RESIDENCE NO. 1628 E. Oliver St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Moritz Braun

6 DATE OF BIRTH (month, day, and year) Dec. 27/1847

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
82	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER John Keller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Francis Wittler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mary F. Braun

(Address) 1628 E. Oliver St

15 Filed ..., 19 ... Registrar

MAR 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1930 March 25

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1930, to Mar 25, 1930, that I last saw h[illegible] alive on Mar 25, 1930, and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Disease of Heart

(duration) 5 yrs. 10 mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W. Sandmann, M. D.

3/27, 1930 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial [illegible] 30

20 UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ E 55464

REGISTERED NO.

E 55464

1-PLACE OF DEATH

City of BALTIMORE: (No. 2023 Eastern Ave 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lubawska

(a) RESIDENCE NO. 2023 Eastern Ave. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Dec. 2, 1903

7 AGE: Years 26 | Months 3 | Days 22 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of indnstry, business, or estnblishment in which emplojed (or employer): 69

(c) Name of employer

9 BIRTHPLACE (city or town): Waynesport

(State or country): Maryland

PARENTS

10 NAME OF FATHER: John Lubawski

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Poland.

12 MAIDEN NAME OF MOTHER: Antonina

12 BIRTHPLACE OF MOTHER (city or town)

(State or country): Poland.

14 Informant: John Lubawski

(Address): 2023 Eastern Ave

15 Filed ..... 19 .....

MAR 26 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1930 March 24,

17 I HEREBY CERTIFY, That I attended deceased from Feb. 13, 1930, to March 23, 1930, that I last saw h[illegible] alive on march 23, 1930, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(durntion) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Fraga, M. D.

, 19 (Address) 2021 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — Date of Burial March 28 1930

20 UNDERTAKER: F. Wozazdwski — ADDRESS: Eastern Ave

1930.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 ✓

E 55465

CERTIFICATE OF DEATH

E 55465

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Work. St. 17-24 Ward)

2-FULL NAME Ola Warrick

(a) RESIDENCE NO. 550 Canal St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11-1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	29		10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Balto City Work
(Address)

MAR 29 1930 C. HAMPSON JONES, M. D.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

GC Fall
Fracture of 12 Dorsal Vr.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? — —

Did operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? History

(Signed) GC Slades M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL 3-26 1930

20 UNDERTAKER Daniel Easter ADDRESS 946 Pennsylvania Ave

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55466

REGISTERED NO. 90 E 55466

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH U.S.F.& G.Building.

City of Baltimore: (No. Redwood & Calvert Sts. St. 10-15 Ward

2-FULL NAME Samuel Stone Stump.

(a) RESIDENCE NO. 405 E.Biddle St- St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	77	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer) Riggs Rossman & Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER A.H.Stump.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Gibson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant A.H.S.Post. (nephew)
(Address) Stevenson, Md.

15 Filed MAR 26 1930 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Arnhardt, M. D.

3/25. 1930 (Address) 1017 E. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Thomas. Cem. Garrison Forrest

DATE OF BURIAL 3-26 1930

20 UNDERTAKER Henry W. Jenkins Sons Co.

ADDRESS Richard Inc Cullola

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 55467

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 55467

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hosp. St. 19-27 Ward)

2-FULL NAME Mary Jones

(a) RESIDENCE NO. 1607 W Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mortimore

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	52	-	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Jas. Harris

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Parker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant James Harris
(Address) 1607 W. Saratoga St.

15 Filed MAR 26 1930 JAMES HARRISON JONES, M. D. Registrar

MAR 26 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns
Victim caught fire from gas stove at home
(accident) (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O'Brooks, M. D.

3/26 1930 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL March 30

20 UNDERTAKER A. Jones ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55468

CERTIFICATE OF DEATH.

101

E 55468

REGISTERED NO. 25-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4316 Belvieu Ave. ST. WARD

2-FULL NAME Marie Stueler Konitzky

(a) RESIDENCE NO. 4316 Belvieu Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of or) WIFE of: John Henry Konitzky

6 DATE OF BIRTH (month, day, and year): April 25 1854

7 AGE: Years 75 Months 11 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10 NAME OF FATHER: Carl Stueler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Etta Konitzky

(Address) 4316 Belvieu Ave

Filed MAR 26 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 25 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 20 1930 to Mar 25 1930

that I last saw he alive on Mar 25 1930

and that death occurred, on the date stated above, at 5-a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Auscultation

(Signed) A. C. Smith M. D.

Mar 26 1930 (Address) 4309 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Mar 25 1930

20 UNDERTAKER: Harry A. Anscott

ADDRESS: 4204 Ridgewood Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Frank Frederick

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55469 X 185 ✓ E 55469

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) W. Balto. Gen. Hosp. (Street) 16-68 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank Frederick

(a) RESIDENCE NO. Hilchester Rd. (St.) Hampden (Ward)
(Usual place of abode)
(If non-resident, give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 26, 1873

7 AGE: Years 56 | Months 6 | Days 26 | If LESS than 1 day, hrs or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Aquilla Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rebecca Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Hugh Carey
(Address): Hilchester Rd.

15 Filed MAR 26 1930 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/24/1930

17 I HEREBY CERTIFY, That I attended deceased from 3/23/1930, to 3/24/1930,
that I last saw h alive on 3/24/30
and that death occurred, on the date stated above, at 8 30 P.m
The CAUSE OF DEATH was as follows: Accident Fell on Rock on farm
Fracture skull

(duration) ... yrs. ... mos 4 ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. 4 ds.

Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) J. V. Castleman, M. D.

(Address) W. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Cem.

DATE OF BURIAL: Mar 27 30

19 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55470 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 55470

47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3706 Woodbine Ave ST. 28-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Gunther

(a) RESIDENCE No. 3706 Woodbine Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Gunther

6 DATE OF BIRTH (month, day, and year) Dec 6th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Pinkus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Schatmel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Charles Gunther

(Address) 3706 Woodbine Ave.

15 Filed MAR 26 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to March, 1930, that I last saw h alive on March 24, 1930, and that death occurred, on the date stated above, at 9:45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mrs. J. Queen, M. D.

3/25 1930 (Address) 3531 Gaywood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balt. Hebrew Cemetery

DATE OF BURIAL 3/26 1930

20 UNDERTAKER E. J. Fanning & Son - 1938 E.

ADDRESS Lafayette Ave.

CAUTION—It is unlawful to make any alteration in this form. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55471

CERTIFICATE OF DEATH

179 V

E 55471

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hosp St. 18-29 Ward)

2-FULL NAME Margaret Klinefelter

(a) RESIDENCE NO. 1017 Boyd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	W hite	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6 1867 1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
74	62	6	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Jessie Klinefelter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Barbara A. Ramsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant E. S. Holloway
(Address) Rudolph Hall Almshouse Bureau

15 Filed MAR 26 1930 19 RAYMOND PIES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns - Clothing caught fire from an exploded flash as she was descending stairs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Brooke M. D.

3/25 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	March 28 1930
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 55472

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55472

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: NO. Caton & Wilkens Aves ST. 20-72 WARD

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Veronica Klimkiewicz

(a) RESIDENCE NO. St Agnes Hospital ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~~

6 DATE OF BIRTH (month, day, and year) Oct 3, 1838

7 AGE: Years 91 Months 5 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister of Charity

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer ~~~

9 BIRTHPLACE (city or town) (State or country): Charles Co. Md.

PARENTS

10 NAME OF FATHER Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER Amelia Langley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charles Co. Md

14 Informant: Sister Mary Clare

(Address) St Agnes Hospital

15 Filed ..... 19 ..... Registrar

HAMILTON JONES, M. D.

MAR 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 24, 1924, to March 25, 1930, that I last saw her alive on 3-25, 1930, and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) George Brenner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: March 29, 30

20 UNDERTAKER: Martin Fahey's Sons — ADDRESS: 1627 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55473 129

REGISTERED NO. E 55473

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Myrtle Ave St. 7-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Ada Gray Harper

(a) RESIDENCE NO. 911 Myrtle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Arthur Harper

6 DATE OF BIRTH (month, day, and year): Oct. 1890

7 AGE: Years 39 | Months 6 | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): Private family

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brunswick Co. Va

PARENTS

10 NAME OF FATHER: Tom J. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MALDEN NAME OF MOTHER: Laura Broadnax

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Arthur Harper

(Address): 911 Myrtle Ave

15 Filed MAR 26 1930, 19 CHARLTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/23/30

17 I HEREBY CERTIFY That I attended deceased from Mar 14th, 1930 to Mar 23rd 1930 that I last saw her alive on Mar 23rd 1930 and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1518 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 3-26 1930

20 UNDERTAKER: Lewis Eastern

ADDRESS: 916 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001

E 55474

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 5-8 WARD)

2-FULL NAME Thomas Sanders

(a) RESIDENCE NO. 115 Reynolds Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 25, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Albert Sanders

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rachael ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed MAR 26 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22-30

17 I HEREBY CERTIFY, That I attended deceased from 2-28-30, 19, to 3-22-30, 19,

that I last saw him alive on 3-22-30, 19,

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic into Cerebrum, left.

(duration) yrs. mos 21 da. ?

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 21 da. ?

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. McClean, M. D.

3-24, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

UNIVERSITY OF MARYLAND

UNDERTAKER

ADDRESS

Commissioner Health

MAR 26 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55475

E 55475

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 1-4-30 Ward)

2-FULL NAME Geo. Lee,

(a) RESIDENCE NO. unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Police Record,
(Address)

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 16th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death by (Accident, homicide, suicide, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Sudden
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

March 16th 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: 19

20 UNDERTAKER

ADDRESS

FRANCIS E. JONES, M. D.
Commissioner of Health

MAR 26 1930

R.—PRINT PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55476

CERTIFICATE OF DEATH.

E 55476
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 933 Page's Court Ward 18-26)

2-FULL NAME Herbert Thomas

(a) RESIDENCE NO. 933 Page's Court Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14
Informant
(Address)

15 Filed MAR 20 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Eugene Feltes M. D.
(Coroner)

3/21, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH CARBON INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

106

MAR 20 1930

E. HAMPSON JONES, M.D.
Commissioner of Health

THE MORGUE

UNIVERSITY OF MARYLAND

E 55477. HEALTH DEPARTMENT—CITY OF BALTIMORE E 55477

CERTIFICATE OF DEATH.

100-0

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 403 N. Schroeder St. 18-76 WARD)

REGISTERED No. C .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Willard

(Residence in Baltimore: No. 403 N. Schroeder St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Negro

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, ..., 1 .....
(Month) (Day) (Year)

7-AGE, 1 yrs. 7 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, John Willard

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Filed, ... 19..... C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 25, 1930
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Primary Broncho-pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas W. Miles M. D.
(Coroner.)

3/26 1930 (Address) 229 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND DATE OF BURIAL, ... 19....

20-UNDERTAKER Commissioner Health. ADDRESS MAR 26 1930

Per. Wm. E. WOODALL

MAR 26 1930

THE MORGUE

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55478

CERTIFICATE OF DEATH

90 E 55478

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1224 Edythe St.) (5-8 Ward)

2-FULL NAME John Burnett

(a) RESIDENCE NO. 1224 Edythe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant N.E.Polce Dept
(Address)

15 Filed MAR 26 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardio-Renal Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no (Hopkins)

What test confirmed diagnosis? History treated at

(Signed) [signature] M. D.

3/25/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS MAR 26 1930

MAR 26 1930 LAMPRON JOHNS, M.D.

1185 THE MORGUE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55479

CERTIFICATE OF DEATH

38 E 55479

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1305 H. Alley St., 5-8 Ward)

2-FULL NAME George Bailey

(a) RESIDENCE NO. 1305 H. Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Black	married

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Police Dept.
(Address)

Filed MAR 26 1930, 19
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 13/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Syphillis (Central Nervous)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr. J. E. Fisher

(Signed) J. E. Fisher, M. D.

3/25/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M. D.
Commissioner of Health.

THE MORGUE

UNIVERSITY OF MARYLAND

MAR 26 1930

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55480 ✓

E 55480

CERTIFICATE OF DEATH

× 100-007

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ____ ST., 12-44 WARD)

2—FULL NAME Mrs. Mary Lubba

(a) RESIDENCE NO. St. Michaels - Talbot County - Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ____ da. ____ How long in U. S., if foreign birth? yrs. ____ mos. ____ da. ____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Fred Lubba

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	75	5 4	12 15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) St. Michaels
(State or country) Talbot County - Md.

PARENTS

10 NAME OF FATHER James Barnes

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Luisa Plummer

13 BIRTHPLACE OF MOTHER (city or town) St. Michaels
(State or country) Talbot County - Md.

14 Informant Daniel R Barnes

(Address) Royal Oak

Filed APR 26 1930, 19 ____

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1930, to March 25, 1930, that I last saw h. alive on March 25, 1930, and that death occurred, on the date stated above, at 8:20 P m.

The CAUSE OF DEATH* was as follows:

Malignant tumor

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ____ yrs. ____ mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? ____

(Signed) Richard T. Shackelford, M. D.

March 25 1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Michaels Md

DATE OF BURIAL 3/26 1930

20 UNDERTAKER Herman Cook

ADDRESS 12/7 S Paca

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55481

CERTIFICATE OF DEATH.

Hb E 55481

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph Hospital ST. E-16 WARD)

2-FULL NAME Mrs Amanda Schlerf

(a) RESIDENCE NO. 1607 N. Patterson Park Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female
4 COLOR OR RACE: white
5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christine Schlerf

6 DATE OF BIRTH (month, day, and year): June 5th 79

7 AGE: Years 50 Months 9 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Christine Cole.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Amanda Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Pearl Ewell
(Address) 621 N. Milton Ave

15 Filed MAR 26 1930 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to March 26, 1930, that I last saw h er alive on March 26th, 1930, and that death occurred, on the date stated above, at 1:10 A m.

The CAUSE OF DEATH* was as follows:
Carcinoma of os uteri

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of March 25, 1930

Was there an autopsy? None

What test confirmed diagnosis? (Macroscopic)

(Signed) H. H. Slaughter M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltobem. DATE OF BURIAL: March 28th 1930

20 UNDERTAKER: Leo G. Cook ADDRESS: 1743 Patterson Park Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55482

234978
E 55482

CERTIFICATE OF DEATH

X 135

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 1-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William a Hall

(a) RESIDENCE NO. 166 Mt Vernon Ave ST., WARD Portsmouth Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanch Hall

6 DATE OF BIRTH (month, day, and year) Jan - 31-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Business

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER James W Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Jane Copeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Records

(Address) [illegible] HOSPITAL

15 Filed [illegible] 19 [illegible] Registrar

MAR 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1930, to March 26, 1930, that I last saw him alive on March 26, 1930 and that death occurred, on the date stated above, at 6 20 a m.

The CAUSE OF DEATH* was as follows:

Benigne prostatic hypertrophy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicemia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-19-30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I Rodgers Trumbo, M. D.

March 26, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portsmouth Va

DATE OF BURIAL 3/26 1930

20 UNDERTAKER Freeman Cook

ADDRESS 1217 8th Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55483

CERTIFICATE OF DEATH.

38 E 55483

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Viola Schmanski

(a) RESIDENCE NO. 336 Frankelintown Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
W Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August

6 DATE OF BIRTH (month, day, and year) July 4th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	50	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) John Ward Md

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs August Schmanski (Address) 336 Frankelintown Rd

15 Filed APR 28 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-23 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-18 1930 to 3-23 1930, that I last saw h alive on 3-23 1930, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

cirrhosis of liver (duration) yrs mos ds.

CONTRIBUTORY (Secondary) bleeding from oesophageal varices (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Cecil Breen M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL Mar 26 1930

20 UNDERTAKER E. B. Wippert — ADDRESS 150 W Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

APR 26 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55484

179 E 55484

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Agnes Hosp. St. 20-28 Ward)

2-FULL NAME Mrs Katherine Nine

(a) RESIDENCE NO. 2008 Wilhelm St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm F. Nine

6 DATE OF BIRTH (month, day, and year) Feb 15 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	1	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer M d

9 BIRTHPLACE (city or town) M d
(State or country)

PARENTS

10 NAME OF FATHER George K Watt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) M d

12 MAIDEN NAME OF MOTHER Elizabeth McCarthy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) M d

14 Informant F Rodgers
(Address) 1510 E. Balto

15 Filed MAR 6 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burns - Clothes caught fire from gas stove
Shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

3/25 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Mar 26 1930
20 UNDERTAKER	ADDRESS
F. O. Wagner	150 N Eutaw

FAILURE TO WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55485

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 185 E 55485

CITY OF BALTIMORE: (No. 104 S. Franklintown St. WARD) 9964

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henriette Lang

(a) RESIDENCE No. 104 S. Franklintown ST. Sec WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 11 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles J. Lang

6 DATE OF BIRTH (month, day, and year): April 10th 1845

7 AGE: Years 84 | Months 10 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Carl. Krentzer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Annie Beck

(Address) 104 S. Franklintown Rd

15 Filed MAR 26 1930, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 24 30

17 I HEREBY CERTIFY, That I attended deceased from 2/15, 1930, to Mar 24, 1930,

that I last saw her alive on Mar 24, 1930

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Fracture Left Hypostatic Pneumonia, Senile Asthenia

(duration) yrs. mos. 38 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical.

(Signed) Estella Hemming, M. D.

3/25, 1930 (Address) 2000 Hallins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Mar 27th 1930

20 UNDERTAKER: F. B. Wehrmut — ADDRESS: 150 N. Gilto St

HAMPSON JONES, M.D.

Information should be carefully supplied. All items should be filled. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55486

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55486

100-00

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 17-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Somerville

(a) RESIDENCE NO. 411 N. Pine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45?			

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Williams Somerville

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed APR 2 6 1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24-30

17 I HEREBY CERTIFY, That I attended deceased from 2-25, 1930, to 3-24, 1930, that I last saw h[illegible] alive on 3-24, 1930, and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

Cellulitis right foot

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. H. Hampson, M. D.

3-26, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 3-27 1930

UNDERTAKER Daniel Carter

ADDRESS 916 Gay ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55487

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 55487

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1438 Haubert St. 24-35 WARD)

2-FULL NAME Million E Brigerman

(a) RESIDENCE NO. 1438 Haubert St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Rinker

6 DATE OF BIRTH (month, day, and year) March 15 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	✓	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator 074

(b) General nature of industry, business, or establishment in which employed (or employer) Shipwork

(c) Name of employer Bullo Steamship Co

9 BIRTHPLACE (city or town) (State or country) Bullo Md

PARENTS

10 NAME OF FATHER Georgr Brigerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bullo Md

12 MAIDEN NAME OF MOTHER Mary Vickery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bullo Md

14 Informant Mrs Bertha Brigerman
(Address) 1438 Haubert St.

15 Filed APR 26 1930 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24. 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20 to March 24 1930, that I last saw h[illegible] alive on March 22 1930, and that death occurred, on the date stated above, at 5 Hrs 9 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Anemia

(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? .....

(Signed) H. E. Mun, M. D.

March 26, 1930 (Address) 516 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL March 27 1930

20 UNDERTAKER Charles L. Stevens — ADDRESS 1561 E Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55488

CERTIFICATE OF DEATH.

REGISTERED NO. 1001 E 55488

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 717 S. Dean ST. 16-37 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clair Alfred Byroade (Jr)

(a) RESIDENCE NO. 717 S. Dean ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2 4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Clair A. Byroade

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Lorena Slick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Mr. C. A. Byroade
(Address) 717 S Dean St

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1930

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to March 26, 1930, that I last saw h[illegible] alive on March 25, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Primary Broncho-pneumonia

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

3/26, 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sherwood Pa

DATE OF BURIAL Mar 26 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Aliceanna

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55489

CERTIFICATE OF DEATH

90 E 55489

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Fayette W Day St., 8-45 Ward

2-FULL NAME Charles H Jr Funk

(a) RESIDENCE NO. 2853 Chesterfield St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna M Funk

6 DATE OF BIRTH (month, day, and year): Oct 4 188[illegible]

7 AGE: Years 48 | Months 5 | Days 19 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Supt Balto P.C.
(b) General nature of industry, business, or establishment in which employed (or employer): M.E.
(c) Name of employer: U S. 0.86

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Henry Funk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs Anna Funk
(Address) 2835 Chesterfield

15 Filed ....., 19..... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. ..... mos. — ds.

CONTRIBUTORY (Secondary) E Rawlins

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical History

(Signed) H C Eades, M. D.

, 19 (Address) 743 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem

DATE OF BURIAL: Mar 28 1930

20 UNDERTAKER: John Ulrich

ADDR 2

APR 2 1930

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55490

CERTIFICATE OF DEATH.

E 55490

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) W Lynn Hosp ST. (or) WARD) W-69

2-FULL NAME John E Webb

(a) RESIDENCE NO. 2446 W Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Aug 2-1875

7 AGE — Years: 54 — Months: 7 — Days: 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John H Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Emma Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Laura Webb (Address) 2446 W. Baltimore St.

15 Filed: MAR 26 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/26/30 19

17 I HEREBY CERTIFY, That I attended deceased from March 21st, 19 30, to March 26th, 19 30, that I last saw her alive on March 26th, 19 30, and that death occurred, on the date stated above, at 1.12 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Pneumonia

Appendicitis with Abscess

(duration), yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of March 25/30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Geo E Webb M. D.

19 (Address) 2300 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: Mar 29 1930

20 UNDERTAKER: John Ulrich

ADDRESS: 200 E Preston

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

E 55491

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55491

CERTIFICATE OF DEATH.

REGISTERED NO. 84

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2814 E. Baltimore ST.) 6-11 (WARD)

2-FULL NAME Charles J. Schaffer

(a) RESIDENCE NO. 2814 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Schaffer

6 DATE OF BIRTH (month, day, and year) July 1 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sterotyper

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederick Ortan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Schaffer

(Address) 2814 E Baltimore St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/30

17 I HEREBY CERTIFY, That I attended deceased from 3/10/30, 19.... to 3/25/30, 19....

that I last saw him alive on 3/23/30, 19....

and that death occurred, on the date stated above, at 8:15 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) F. W. Hartman, M. D.

(Address) 7913 E. Balto

3/26/30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Mar 29 1930

20 UNDERTAKER John Ulrich

ADDRESS 2108 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-
TION is very important See instructions on back of certificates.

MAR 26 1930 C. HUDSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 55492 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 55492

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 W. Montgomery St.) 22-31 (WARD)

2-FULL NAME Henrietta Mehrling

(a) RESIDENCE NO. 131 W. Montgomery ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caspar Mehrling.

6 DATE OF BIRTH (month, day, and year) Jan 2 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	2	22	

8 OCCUPATION OF DECEASED At home

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Strobel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Friedericka Bilz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Augusta Buchanan (Address) 131 W Montgomery

15 Filed ... 19 ... C. HAMPSON JONES, M. D. (Registrar)

R 26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24/1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27th, 1930, to March 24, 1930, that I last saw h[illegible] alive on March 24th 1930, and that death occurred, on the date stated above, at 11.30 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) ... yrs. 1 mos 25 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ... yrs. ... mos. 25 ds.

18 Where was disease contracted If not at place of death? At place of death

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Typical findings

(Signed) Stony Leibel M. D.

(Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Mar 27 1930

20 UNDERTAKER John Ellis

ADDRESS 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55493

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55493

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2725 Guilford Ave 17-50 WARD)

2-FULL NAME John C. Dollack

(a) RESIDENCE NO. 2725 Guilford Ave WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Agnes Montgomery

6 DATE OF BIRTH (month, day, and year) Aug 1- 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	36	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant,

(b) General nature of Industry, business, or establishment in which employed (or employer) 008

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Dollack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Agnes Dollack

(Address) 2725 Guilford Ave

15 Filed C. HAMPSON JONES, M.D. Registrar

Pat

26 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25- 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 9- , 1930, to Mch 25 , 1930, that I last saw him alive on Mch- 24 , 1930, and that death occurred, on the date stated above, at 12 30 - a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. 2 mos 25 ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? X Ray

(Signed) E Gill Hall, M. D.

Mch 27 1930 (Address) 1631 E North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL Mar 27 1930

20 UNDERTAKER John Ulrich

ADDRESS 2108 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55494

REGISTERED NO. 74 E 55494

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Redwood & Paca St. 28-6 Ward

2-FULL NAME Harry Ward Barrington

(a) RESIDENCE NO. 4360 Springdale St., Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
About	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Edw. Barrington

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Zelia Furz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa

14 Informant Robert H. LaPorte
(Address) Reisterstown, Md

Filed MAR 26 1930, 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Zeller M. D.

3/26. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL Mar 27 1930

20 UNDERTAKER J. J. Tickner & Sons — ADDRESS N. Pa Ave

R. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55495

E 55495

CERTIFICATE OF DEATH.

11-002

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 3601 Mary ave. St. 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel James Fitch

(a) Residence No. 3601 Mary ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 23 1929

7-AGE. yrs. 9 mos. 2 ds. If LESS than 1 day, hrs. or 30 min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md.

PARENTS.

10-NAME OF FATHER. Arthur D. Fitch

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Theresa Fitch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore

14- (Informant) Arthur D. Fitch

(Address) 3601 Mary Ave.

15- Filed 3-26 1930

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 25/30

17- I HEREBY CERTIFY, That I attended deceased from March 18 1930 to March 25 1930

that I last saw him alive on March 24 1930

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia and Heart failure.

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Anemia

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms Physical Signs

(Signed) John F. Conway M. D.

19 (Address) Medical Arts Bldg.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem

DATE OF BURIAL. 3/27/30.

20-UNDERTAKER. Mary T. Duffy

ADDRESS 1735 Harford

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

MAR 26 1930

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55496

CERTIFICATE OF DEATH

49 E 55496

1—PLACE OF DEATH Md Gen Hosp REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 6-9 WARD)

2—FULL NAME Charles Cooch

(a) RESIDENCE NO. 1811 Jackson pl ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Charles Cooch

6 DATE OF BIRTH (month, day, and year) Mar 29-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cloakroom Cleaner

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Jacob Cooch.

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Eubora G

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Hospital Records (Address) .....

15 FILED ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 17-1930, 19..., to Mar 24, 1930, that I last saw him alive on Mar 24, 1930 and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder (Cystic).

..... (duration) yrs. ? mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation 15 min

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Mar. 22-1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos A Thompson, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Moriah Hampstead DATE OF BURIAL 3/27 1930

20 UNDERTAKER J. M. Cook ADDRESS 2172 Ford Av

C. HAMPSON JONES, M. D.

MAR 26 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55497

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55497

CERTIFICATE OF DEATH

1—PLACE OF DEATH Frankelin Square Hosp. REGISTERED NO. 40

CITY OF BALTIMORE: (No. ..... ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Edna Eason.

(a) RESIDENCE NO. 1222 W. 37th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frederick Eason

6 DATE OF BIRTH (month, day, and year) Aug 24-1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator 609

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Stonewall J Campbell

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Minnie Fletcher

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Frederick Eason

(Address) 6 W W 33rd St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MAR 6 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/30

17 I HEREBY CERTIFY, That I attended deceased from 3/21, 1930, to 3/25, 1930, that I last saw h.. alive on 3/25, 1930, and that death occurred, on the date stated above, at 8 40 P.m.

The CAUSE OF DEATH* was as follows:

Terminal bronchio-pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Pelvic inflammatory disease

E peritonitis (duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 3/21/30

Was there an autopsy? No Planned prior to death

What test confirmed diagnosis? Clinical picture.

(Signed) F. K. Schreiber, M. D.

, 19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery

DATE OF BURIAL 3/28 1930

20 UNDERTAKER William Cook

ADDRESS 1111 St Paul St

Notice should be carefully supplied. Any mistake or omission may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

✓ Dr Litman

E 55498

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 E 55498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~2207~~ 1053 N Central Ave Ward) 10-14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lavinia C. Steers

(a) RESIDENCE NO. 1053 N Central Ave St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Jacob Steers

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 78				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Adams Co Penna

PARENTS

10 NAME OF FATHER Earl Shanabrook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Lizzie Rife

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Martha Shanabrook

(Address) 1053 N. Central Ave

15 Filed APR 2 6-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/1930

17 I HEREBY CERTIFY, That I attended deceased from 3/16/30, 19, to 3/25/30, 19, that I last saw her alive on 3/25/30, 19, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Irving J. Litman, M. D.

, 19 (Address) 1304 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 3/27/1930

20 UNDERTAKER J. H. Cook

ADDRESS 1217 E Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 55499 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55499

CERTIFICATE OF DEATH.

90

25-76

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE (No. 3108 Remley Street Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Tolodzieckis

(a) Residence No. 3108 Remley St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Noomi

6-DATE OF BIRTH (month, day and year) Oct 13-1888

7-AGE. 41 yrs. 5 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Self 016

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER. John Tolodzieckis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Magdalena

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14-Informant Agnes Barahamer

(Address) 3121 Remley St.

15- C. HAMPSON JONES, M. D. Registrar.

MAR 26 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 26/30

17- I HEREBY CERTIFY, That I attended deceased from March 16 1930 to March 24 1930

that I last saw h[illegible] alive on March 24 1930

and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

Chronic Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Leon J. Hosta M. D.

3/25 1930 (Address) 4700 Kenwood Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross. B A C.

DATE OF BURIAL. Mar 27 1930

20-UNDERTAKER. William Cook

ADDRESS 1217 St Paul St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55500

CERTIFICATE OF DEATH.

REGISTERED NO. E 55530

1-PLACE OF DEATH: Baltimore City Hospitals ST. 19-29 WARD) 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME: William L. Brown

(a) RESIDENCE NO. 1309 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): April 19, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Thomas J. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary J. Rowilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records of Balto. City Hosp. (Address)

15 Filed MAR 27 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-28-30

17 I HEREBY CERTIFY, That I attended deceased from 3-17-30, 19..., to 3-28-30, 19...,

that I last saw him alive on 3-28-30, 19...,

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvey M. McClean, M. D.

Balto. City Hosp.

3-26 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery

DATE OF BURIAL: 3/28/1930

ADDRESS

20 UNDERTAKER: Wm Cook 1217 St Paul st

N.B.—WRITE PLAINLY, with ink, and answer all questions fully and correctly as far as information is supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful in stating CAUSE OF DEATH. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. In plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-12-23—M&T—500 Blks.

E 55501 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55501

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Vol. America Hospital (St.) 685 (WARD) 101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Burns

(a) RESIDENCE NO. 655 Charlotte ST., WARD

(Usual place of abode) Detroit, Mich. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER John Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elz Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Francis Burns

(Address) 234 N. Walnut Lane Chelsea

15 Filed 2 7 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 25 1930

17

I HEREBY CERTIFY, That I attended deceased from Mch 17, 1930, to Mch 25 1930

that I last saw h[illegible] alive on Mch 25, 1930

and that death occurred, on the date stated above, at 8.20 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? stethoscope

(Signed) A. F. Conrey, M. D.

, 19 (Address) Vol. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Trinidad Colo.

DATE OF BURIAL 3/27/1930

20 UNDERTAKER William Cook

ADDRESS 1117 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT [illegible] RD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55502 235116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 84 ✓ E 55502

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Talmage Wilson

(a) RESIDENCE NO. Winnsboro S. Car ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) S. C.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Frank Wilson

11 BIRTHPLACE OF FATHER (city or town) S. Car
(State or country)

12 MAIDEN NAME OF MOTHER Clara Peake

13 BIRTHPLACE OF MOTHER (city or town) S Car
(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26-1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to March 26, 1930, that I last saw h.m alive on March 26, 1930, and that death occurred, on the date stated above, at 6 45 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor Brain Stem Glioma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-25-30

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) C D Briggs, M. D.

3/27, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Winnsboro S. C.	Mch 29 1930
20 UNDERTAKER	ADDRESS
John D. Mitchell & Sons	1900 Eutaw Place

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 55503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

197 ✓E 55503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 640 W. North Ave St. 19 Ward)

2-FULL NAME Ruth L. Hewitt

(a) RESIDENCE NO. 640 W. North Ave St. 19 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John E. Hewitt

6 DATE OF BIRTH (month, day, and year): Feb 19 1881

7 AGE — Years: 44 — Months: 1 — Days: 6 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 637

(b) General nature of industry, business, or establishment in which employed (or employer): autos

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Wm H Funk

11 BIRTHPLACE OF FATHER (city or town): Penna

(State or country)

12 MAIDEN NAME OF MOTHER: Mary B. Sibbett

13 BIRTHPLACE OF MOTHER (city or town): Penna

(State or country)

14 Informant: Josie M. Hewitt

(Address) 640 W. North Ave

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9-25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

THE CAUSE OF DEATH was as follows: Gun shot wound through head & throat (Homicidal)

..... (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

..... (duration) .....yrs. .....mos. .....ds.

(Signed) John J. Morrissey M. D.

(Coroner)

3/26 1931 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Park Date of Burial: Mch 27 1930

20 UNDERTAKER: John C. Middleton ADDRESS: Pimlico Station

N. B.—WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 55504

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55504

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph's Hospital St. 13-20 Ward)

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Hewitt

(a) RESIDENCE NO. 640 W. North Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth L. Hewitt

6 DATE OF BIRTH (month, day, and year) Apr. 29, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	49	10	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Train Dispatcher
(b) General nature of industry, business, or establishment in which employed (or employer) W. Md. R. R.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) W. Va.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Wm. E. Hewitt
(Address) 640 W. North Ave.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wounds in right temple and roof of mouth. (Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 640 W. North Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Wallis, M. D.

Mar. 26, 1930 (Address) 508 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Mch 12 '30 19
20 UNDERTAKER John O. Mitchell & Sons,	ADDRESS 1900 Eutaw P

MAR 27 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 55505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 55505

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 714 N. Duncan ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Valis

(a) RESIDENCE NO. 714 N. Duncan ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Valis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Valis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Frank Valis

(Address) 710 N. Durham St

15 Filed MAR 27 1930 C. HAMPSON JONES, M. D. Registrar

by [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26/30

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1930, to March 26, 1930, that I last saw him alive on March 26 - 1930 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia - 2 days

Cardio - vascular - renal disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension - Chr. arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No -

What test confirmed diagnosis? Physical exam.

(Signed) Louis F. Krumenacker, M. D.

, 19 (Address) 722 N. Kenwood Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar 28 1930

20 UNDERTAKER Frank Veach & Son — ADDRESS 1916 Eastland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 55506 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 5 E 55506

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 725 N. Glover ST., 7-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna B. Ruzicka

(a) RESIDENCE NO. 725 N. Glover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Frank Ruzicka

6 DATE OF BIRTH (month, day, and year) Sept 18/49

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Bilek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Vanlamon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Josephine Ruzicka

(Address) 725 N. Glover St

15 Filed MAR 27 1930 JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25/30

17 I HEREBY CERTIFY, That I attended deceased from March 25 19 30 to March 25 19 30

that I last saw her alive on March 25 19 30

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Bauer M. D.

Mar 27 30 (Address) 801 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL March 29 1930

20 UNDERTAKER Frank Crook Son 1906 Eastern Ave — ADDRESS Baltimore

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55507

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 55507

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N. Glover ST. 6-10 WARD)

2-FULL NAME George T.W. Schaeffer

(a) RESIDENCE NO. 407 N. Glover ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 27/02

7 AGE — Years: 27 — Months: 3 — Days: 28 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Brom El. Co.

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Philip W. Schaeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Veronica Horstschneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Veronica Schaeffer
(Address) 407 N. Glover St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 25/30

17 I HEREBY CERTIFY, That I attended deceased from February 26, 1930 to Mar 25, 1930, that I last saw him alive on Mar 25, 1930, and that death occurred, on the date stated above, at 11 55 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 8 months

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage (duration) ..... yrs. ..... mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. T. Geyer, M. D.

19 (Address) 156 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Pk. — DATE OF BURIAL: 3/28/30

20 UNDERTAKER: Philip Herring — ADDRESS: 2016 Orleans St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55508

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55508

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 105 N. Wolfe Street 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Coheh

(a) RESIDENCE NO. 119 N. Wolfe Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adrill Cohen

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72 [redacted]	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E. Balt St

15 MAR 27 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 22nd, 1930, to Mar 26th, 1930, that I last saw h[illegible] alive on Mar 25th, 1930, and that death occurred, on the date stated above, at 4-20 9 m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation
Myocardial Degeneration
Cardiac Decompensation

one

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis Clinical Exam

(Signed) A. Plus, M. D.

Mar 26 1930 (Address) 24 S. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrem Hebrew Rem

DATE OF BURIAL 3/27 1930

20 UNDERTAKER Jack Lewis 1439 E Balt St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55509

101-001 E 55509

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 N. Caulton St., 18-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Griffin

(a) RESIDENCE NO. 237 N. Caulton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fml

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clarence Griffin

6 DATE OF BIRTH (month, day, and year): 8-9-93

7 AGE: 37 Years 36 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Edward Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Judie Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Clarence Griffin

(Address): 237 N. Caulton Ave

15 Filed MAR 27 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24th 1930

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1930 to March 24, 1930

that I last saw her alive on March 23, 1930

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) E. E. Lucy M. D.

(Address) 2 Belle Air Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Star Cemetery — DATE OF BURIAL: Mar. 27, 1930

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 3221 Schroeder St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55510

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55510

nf-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3544 Ninth St. Brooklyn WARD 25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hedwig Loffler

(a) RESIDENCE NO. 3544 Ninth ST., Brooklyn WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Loffler

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Hedwig Schmick

(Address) 3544 Ninth St.-Brooklyn

15 Filed MAR 27 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 21, 1930, to Mar. 25, 1930, that I last saw her alive on Mar. 24 — , 1930 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH was as follows: Cerebral Hemorrhage

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted, if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) X Murray Lo M. D.

3/26, 1930 (Address) 1341 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Mar 27 1930
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

mation should be carefully supplied. A.E should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55511

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55511

101-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 218 N. Castle St. 6-9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia E. Mauer

(a) RESIDENCE NO. 218 N. Castle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Mauer

6 DATE OF BIRTH (month, day, and year) March 24/1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	0	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N.J.

PARENTS

10 NAME OF FATHER Erastus Brant

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.J.

12 MAIDEN NAME OF MOTHER Margaret Miller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mattie Mauer
(Address) 218 N. Castle. M

15 Filed MAR 27 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25/'30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) History of Pneumonia 3 weeks before (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. V. Katen, M. D.

3/27/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Mch 29 1930
20 UNDERTAKER	ADDRESS
Chas. E. Francis	837 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 55512 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 55512

CERTIFICATE OF DEATH. X 47

1-PLACE OF DEATH Howard A Kelly Hospital

CITY OF BALTIMORE: (NO.) 1418 Eutaw ST. 17-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Frances Hite Shuse

(a) RESIDENCE NO. 747 Franklin St. ST., WARD Los Angeles

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ (or) WIFE of Mrs. John C. Shuse

6 DATE OF BIRTH (month, day, and year) June 11, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Houston Texas

PARENTS

10 NAME OF FATHER Cadwallader Hite

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lexington Kentucky

12 MAIDEN NAME OF MOTHER Fannie B Rendshaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Major John C. Shuse

(Address) Los Angeles Cal.

Filed MAR 27 1930, 19 ..... G. HAMPSON WHITE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 7, 1930, to March 26, 1930, that I last saw h e alive on March 26, 1930 and that death occurred, on the date stated above, at 12 • 10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

with

Metastases to Spine, rib, pelvis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac + aortic

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1924

Was there an autopsy? no

What test confirmed diagnosis? microscopic Examination

(Signed) J. A. Brown, M. D.

March 26, 1930 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Cremation DATE OF BURIAL March 28 1930

20 UNDERTAKER Chas. G. Black ADDRESS 142 Ellworth Ave

S.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 55513 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 55513

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 Brevard ST. 11-24 WARD)

2-FULL NAME Bessie Johnson

(a) RESIDENCE NO. 928 Brevard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Johnson

6 DATE OF BIRTH (month, day, and year) ? 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) unk

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) unk (State or country)

14 Informant James Johnson (Address) 928 Brevard St

15 Filed MAR 27 1930 H. HAMPSON JACKS M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1930, to Mar 24, 1930, that I last saw her alive on Mar 24, 1930 and that death occurred, on the date stated above, at 11 p m

The CAUSE OF DEATH* was as follows:

Cardio Renal

(duration) yrs. 2 mos 22 ds.

CONTRIBUTORY (Secondary) Hemoglobinuria

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No Physical

What test confirmed diagnosis?

(Signed) Geo. S. Adler, M. D.

3-26 1930 (Address) 508 Summit Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 3/27/1930

20 UNDERTAKER Geo. H. Holland — ADDRESS 1631 Druid Hill

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55514 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 55514

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 N. Gay Street ST.) 8-17 (WARD)

2-FULL NAME Bessie Rossman

(a) RESIDENCE NO. 1209 N. Gay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Rossman

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Stuckas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lasch —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ella Rossman

(Address) 1209 N. Gay St

15 Filed MAR 27 1930 Registrar

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27/30

17 I HEREBY CERTIFY, That I attended deceased from April, 1928, to March 26, 1930, that I last saw h[illegible] alive on March 26, 1930, and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Mitral Insufficiency
Arterio-Sclerosis

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Jack Cohen, M. D.

3/27, 1930 (Address) 223 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 3/28 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55515 21 ✓

1—PLACE OF DEATH

REGISTERED NO. E 55515

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 8-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ola Galley

(a) RESIDENCE NO. 3426 Ravenwood Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. N. Galley

6 DATE OF BIRTH (month, day, and year) Jan 13, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	35	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER T. O Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Lillie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Jos. N. Galley
(Address) 3426 Ravenwood Ave

15 Filed ....., 19 .....

C. HAMILTON JONES, M. D.
Registrar

MAR 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1930

17

I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to March 26, 1930, that I last saw h[illegible] alive on March 26, 1930 and that death occurred, on the date stated above, at 6 15 p m.

The CAUSE OF DEATH* was as follows:

Facial Erysipelas
(Idiopathic)
(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G Tull, M. D.

3/26, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL 3/28 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 E Pratt St

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

235311 E 55516 × 90

1—PLACE OF DEATH

REGISTERED NO. [illegible]

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2—FULL NAME Daniel Wiley Crumlich

(a) RESIDENCE NO. 6708 Bessemer Ave, ST., Dundalk Md, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lina Crumlich

6 DATE OF BIRTH (month, day, and year) May 17, 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pump Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Henry Crumlich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Eliza Wiley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MAR 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 24, 1930, to Mar. 26, 1930, that I last saw him alive on Mar. 26, 1930 and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
Cardiac decompensation
Auricular fibrillation

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wendell S. Muncie, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 3/28 19 30

20 UNDERTAKER Wm Cook

ADDRESS 1317 E Pond St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Dr Finby 3522 Greenmount Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55517

CERTIFICATE OF DEATH.

49 E 55517

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4618 York Road ST., 27-48 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Philip Frank Risser

(a) RESIDENCE NO. 4618 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose

6 DATE OF BIRTH (month, day, and year) July 30-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Peter Risser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Augustina Guerra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Wife 4618 York Road

15 Filed ..... 19 ..... H. HAMILTON JOHNS, M. D. Registrar

AR 71630

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26-1930

17 I HEREBY CERTIFY, That I attended deceased from January 12, 1930, to March 26, 1930, that I last saw him alive on March 25, 1930, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Asylum & death

Did an operation precede death? Yes Date of June 1930

Was there an autopsy? no

What test confirmed diagnosis? Clinical cooperation

(Signed) Wm L Finby, M. D.

3/20, 1930 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cem	May 29 1930

20 UNDERTAKER ADDRESS

H. M. Cook 1215 E. Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Duker 928E 1st st

E 55518 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55518

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1903 Boone St. 9-46 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Catherine Mueller

(a) RESIDENCE NO. 1903 Boone ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Saul F Mueller

6 DATE OF BIRTH (month, day, and year): Nov 11 1864

7 AGE — Years: 65 — Months: 4 — Days: 15 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Ed Tolle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Saul Mueller Jr (Address) 508 Roberts Ave Govans

15 Filed MAR 27 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 26 1930

17 I HEREBY CERTIFY, That I attended deceased from MAR 15 1930, 19..., to MAR 26 1930, that I last saw he alive on MAR 26 1930, 19..., and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH was as follows:

Acute Dilatation of heart with acute Pleurisy & Influenza

(duration) 2 yrs. X mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 12 yrs. 6 mos. X ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of None

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O. H. Duker, M. D.

3/27 1930 (Address) 928 6 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 3/29 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1219 E Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 55519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-03 E 55519

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Carson Ct S. 16-23 WARD)

2-FULL NAME Nancy Thomas

(a) RESIDENCE NO. 1112 Carson Ct ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamen Thomas

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 31; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co Md

PARENTS

10 NAME OF FATHER: William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): A. A. Co Md

12 MAIDEN NAME OF MOTHER: Harriet Sassaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. A. Co Md

14 Informant: Carrie Dickerson

(Address) 917 N Caley St

15 Filed , 19 Registrar

MAR 27 1930 C. HAMPSON JONES, M. D. Health Commissioner

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 24 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1930, to Mar 24, 1930, that I last saw h e alive on Mar 23, 1930, and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Ivey, M. D.

3/27, 1930 (Address) 1708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetary

DATE OF BURIAL: Mar 27 1930

20 UNDERTAKER: Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Linares

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55520 ✓ X108 E 55520

CERTIFICATE OF DEATH

E 55520

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital 30 WARD)

2—FULL NAME Fred Linares

(a) RESIDENCE NO. Severn DeLeb ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. mos. 8 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) March 9, 1905

7 AGE: 25 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Severn DeLeb

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER Robt Linares

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Sybella Marks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant Thomas Linares

(Address) Baltimore Md

15 Filed MAR 27 1930 H. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/30

17 I HEREBY CERTIFY, That I attended deceased from 3/19, 1930, to 3/27, 1930, that I last saw him alive on 3/27, 1930 and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Endocarditis Angina.

Extensive thrombosis of cerebral tissues of Brain.

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Infection, Hemorrhage,

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of 3/19/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings by visual examination

(Signed) Fonger Yeager, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: March 1930

UNDERTAKER: H. H. Webb

ADDRESS: Greenmount Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 E 55521

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 707 E. Chase St. 10-14 WARD)

2-FULL NAME Michael D. O'Dea

(a) RESIDENCE NO. 707 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct. 31, 1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lieut. Fire 232

(b) General nature of industry, business, or establishment in which employed (or employer) Department

(c) Name of employer City

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Michael V. O'Dea

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Margaret Welby

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs. Margaret O'Dea

(Address) 707 E. Chase St.

15 Filed MAR 27 1930 19 R. L. H. Registrar

C. HERBERT JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to March 26, 1930, that I last saw him alive on March 26, 1930, and that death occurred, on the date stated above, at 12 h m.

The CAUSE OF DEATH* was as follows:

Acute Pancreatic Hepatitis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Exhaustion a Leoma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm S Gage, M. D.

3/27/30 (Address) 709 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Mar 29, 1930

20 UNDERTAKER: Edward W. Conklin — ADDRESS: 924 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

86-001 V

E 55522

REGISTERED NO.

1—PLACE OF DEATH Md. General Hospital

CITY OF BALTIMORE: (No. ST., 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice N. Grimes

(a) RESIDENCE NO. 605 S. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 10, 1929

7 AGE: Years 7 mo. | Months 7. | Days 16 | If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Vernon Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Daisy Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Hospital records

(Address)

15 Filed ... 19 ... By ... Registrar

C. HAMPSON JONES, M. D.

MAR 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/26/30

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 1930, to 3/26, 1930, that I last saw h[er] alive on 3/26, 1930 and that death occurred, on the date stated above, at 5:33 P. m.

The CAUSE OF DEATH* was as follows:

Acute otitis media

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary): Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

3/26/30 (Signed) J. A. Crumpton M. D.

(Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: Mar 28 1930

20 UNDERTAKER: Jno. Mrs. J. W. Teufel & Son

ADDRESS: 801 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55523

CERTIFICATE OF DEATH.

74001

E 55523

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3410 Elliott ST. No 37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wachter

(a) RESIDENCE NO. 3410 Elliott ST. 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Catharine Wachter

6 DATE OF BIRTH (month, day, and year) April 6th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Wachter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Schaefer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Wachter (Address) 3410 Elliott St

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

MAR 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25/30

17 I HEREBY CERTIFY, That I attended deceased from June 1 1926 to March 25 1930, that I last saw him alive on March 25 1930, and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) A. L. Long, M. D.

March 26 1930 (Address) 2711 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL March 29 1930

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55524

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55524

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3304 Keswick Road. ST. 13-52 WARD)

2—FULL NAME Inez Beulah Hackley.

(a) RESIDENCE NO. 3304 Keswick Road. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James C. Hackley.

6 DATE OF BIRTH (month, day, and year) Feb 27, 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER James R. Martin.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or country)

14 Informant James C. Hackley.
(Address) 3304 Keswick Road.

15 Filed ..... 19.. C. H. Thompson-Jones M.D.
Registrar

MAR 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1930, to Mar 25, 1930; that I last saw h/w alive on Mar 25, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of leg with metastasis to lungs & mediastinum

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Massive collapse of lungs.

(duration) yrs. mos. ds.

18 Where was disease contracted —
If not at place of death?

Did an operation precede death? Yes Date of Dec 1929.

Was there an autopsy? No

What test confirmed diagnosis? Xray

(Signed) [illegible], M. D.

3/27, 1930 (Address) 846 W 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine Grove Balto Co.	Mar 28, 1930
20 UNDERTAKER	ADDRESS
[illegible]	615 Chestnut

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55525

E 55525 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals 16-37 REGISTERED NO. 90

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bradley Browning

(a) RESIDENCE NO. Balto. City Hosp. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Rufus Browning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed MAR 27 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26-30

17 I HEREBY CERTIFY, That I attended deceased from 2-15-30, 19..., to 3-26-30, 19...,

that I last saw h. alive on 3-26-30, 19...,

and that death occurred, on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic over 1

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

3-27 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LOUDON PARK CEM

DATE OF BURIAL 3/28 1930

20 UNDERTAKER ROBERT B ROOKS SON

ADDRESS Calhoun Hollins St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55526

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 E 55526

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 12-51 ST. EDWARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Hartwell

(a) RESIDENCE NO. Provident Hospital ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	A.A	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/27/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				21 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) obt

(c) Name of employer

9 BIRTHPLACE (city or town) Provident Hosp
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wilson Hartwell

11 BIRTHPLACE OF FATHER (city or town) Glascoe
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Tally Smith

13 BIRTHPLACE OF MOTHER (city or town) Pleasantville
(State or country) Virginia

14

Informant

(Address)

15

Filed 3 27 1930, 19 [illegible] Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-30

17

I HEREBY CERTIFY, That I attended deceased from 3-26-30, 19, to 3-27-30, 19 30, that I last saw h alive on 3-27-30, 19, and that death occurred, on the date stated above, at 2 p., m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W B Butler, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

MAR 27 1930

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55527a

CERTIFICATE OF DEATH.

101 001 E 55527

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5241 Frederick Ave ST. 25-71 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Knull

(a) RESIDENCE NO. 5241 Frederick Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of George Knull

6 DATE OF BIRTH (month, day, and year) April 4th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER John Bucker

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Bavaria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Jno Geo C. Knull
(Address) 5241 Frederick Ave Baltimore Md

15 Filed MAR 27 1930 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 21 1930, to March 25th 1930,
that I last saw h.. alive on March 25th 1930,
and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac failure Cyanosis

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? Or place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas Mackall, M. D.

March 25th, 1930 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prov. Cathedral Cemetery DATE OF BURIAL March 28 1930

20 UNDERTAKER George L. Schwartz ADDRESS 210 Park Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 55528

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 523 E 25th ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Ellen Schofield

(a) RESIDENCE NO. 523 E 25th St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 6-27-1862

7 AGE — Years: 67 — Months: 9 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Schofield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Barbara Daues

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Thomas J Lehan

(Address): 3621 Guilford Ave

15 Filed MAR 27 1930, 19 — C. HAMPSON JONES, M. D. Registrar — By RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/26/30

17

I HEREBY CERTIFY, That I attended deceased from 3/27/29, 19, to 3/26/30, 19, that I last saw her alive on 3/26/30, 19, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis

(duration) ✓ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) I W Gaddess, M. D.

3/27/30, 19 (Address) 521 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Cemetery Govs	March 28 19 30
20 UNDERTAKER	**ADDRESS**
Mary M. Wiedefeld	501 E 22 nd St

IMPORTANT—Answer should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55529 ✓ E 55529

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2510 Francis St. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. S Shockney

(a) RESIDENCE NO. 2510 Francis ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Leonard Shockney

6 DATE OF BIRTH (month, day, and year) June 11, 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Commission

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Lorenzo D. Shockney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Mary J. Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Mrs. Aline Amend

(Address) 2516 Francis St.

15 FILED MAR 27 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 26th, 1930, to March 26th, 1930, that I last saw him alive on March 26th, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Erysipelas (of left Leg & Thigh)

(duration) yrs. mos. 10 days

CONTRIBUTORY (Secondary) Varicose Ulcers of left Leg

(duration) 2 yrs. mos.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual Routine

(Signed) Ebert C. Reitz M. D.

3/27th 1930 (Address) 2221 W. Fallon Av. Balto Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	March 29 1930
20 UNDERTAKER H. H. Ehlen	ADDRESS 3744 Fleet Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Jones
720 North Ave

E 55530

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55530

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1419 E. Biddle St., 1013 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank M Bonnett

(a) RESIDENCE NO. 1419 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11 1853

7 AGE: Years 76 | Months 8 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph L Bonnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Orange

12 MAIDEN NAME OF MOTHER Henrietta Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Mrs. H Adams 1419 E Biddle St

15 Filed MAR 27 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26. 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1929, to March 26, 1930, that I last saw him alive on March 26, 1930, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. moe ds.

CONTRIBUTORY (Secondary)

(duration) yrs. moe. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Jones, M. D.

3/27, 1930 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Drummond

DATE OF BURIAL: 3/28, 1930

20 UNDERTAKER: D Mecani Cook

ADDRESS: 1217 St Paul

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Dr Bayley
2805 N Calvert St

E 55531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 N. Calvert St. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane J. Williams

(a) RESIDENCE (Usual place of abode) No. 2809 N. Calvert ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse W. Williams

6 DATE OF BIRTH (month, day, and year) Feb 27, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 27

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Fleet W. Thrift

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Alvida M. Morrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant James F. Thrift

(Address) 2809 N. Calvert St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1929, to March 25, 1930,

that I last saw h.. alive on March 25, 1930,

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas and Liver

About 4 months

(duration) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Dec 1929

Was there an autopsy? Exploratory Incision at Johns Hopkins Hospital

What test confirmed diagnosis? by Dr. Chas R. Edwards

(Signed) Henry Burt Bayley, M. D.

March 26 / 30 19 (Address) 2805 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL Mar 28 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 28 1930 C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55532

CERTIFICATE OF DEATH

49 E 55532

1—PLACE OF DEATH

REGISTERED NO. 18-76

CITY OF BALTIMORE: (No. 232 N. Amity ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjiman F Goss

(a) RESIDENCE NO. 232 N. Amity ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 4 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

6 DATE OF BIRTH (month, day, and year) Jan 1 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Galt Steam Paving Co

9 BIRTHPLACE (city or town) (State or country) Calvert Co Maryland

PARENTS

10 NAME OF FATHER William H Goss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Maryland

12 MAIDEN NAME OF MOTHER Charlotte Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Maryland

14 Informant William M Rawlings

(Address) 736 N. Carrollton

15 Filed APR 2 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1930

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929 to Mar 26, 1930

that I last saw h alive on Mar 25, 1930

and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) 1 yrs. 4 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dan Francheon, M. D.

3/26 1930 (Address) 172 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Calvert Co. Md. Brooks Chapel

DATE OF BURIAL 3/28 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1399 W. Baltimore St.

IMPORTANT: Answers to questions must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55533

CERTIFICATE OF DEATH

74-001 ✓ E 55533

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 3128 (ST.) Remington Ave (WARD) 12-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pauline E. Smith

(a) RESIDENCE NO. 3128 (ST.) Remington Ave (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. da. How long in U. S., if foreign birth? 77 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles A. Smith

6 DATE OF BIRTH (month, day, and year): Jan. 17-1847

7 AGE: Years 83 | Months 2 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Kresmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William C. Smith

(Address) 3128 Remington Ave

15 Filed APR 2 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1st, 1929, to Mar. 25th, 1930, that I last saw h[er] alive on Mar 25th, 1930 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 da.

CONTRIBUTORY (Secondary): Senility.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. W. E. Cross, M. D.

19 (Address) 28 W 25 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	March 28 1930
20a UNDERTAKER	ADDRESS
Horace H. Burgee	363 Falls Road

IMPORTANT: Physicians should be careful to see that ALL ITEMS are accurately supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

25-901 E 55534

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 N. Patterson Park ave ST., 8th WARD) 12

2-FULL NAME James C. Armstrong

(a) RESIDENCE NO. 1227 N. Patterson Park ave ST., ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredericka Wattmer

6 DATE OF BIRTH (month, day, and year) April 17th 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Jas. S. Armstrong

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Susan Chaney

13 BIRTHPLACE OF MOTHER (city or town) City (State or country)

14 Informant Mrs. Jas. C. Armstrong (Address) 1227 N. Patterson Park ave.

15 Filed ....., 19.... Registrar

FRANKSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 22 1930 to March 25 1930, that I last saw him alive on March 25 1930, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) 4 yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) D O Herzog M.D. M. D.

3/26, 1930 (Address) 1305 N Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 3/28 1930

20 UNDERTAKER E. J. Timanus Inc - 1386 — ADDRESS Lafayette ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

MAR 27 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55535

CERTIFICATE OF DEATH

129 ✓ E 55535

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1917 E. Lafayette St. 1622 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Mary Fenlstich

(a) RESIDENCE NO. 1917 E. Lafayette St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widows

a If married, widowed, or divorced
H~~usband~~ (or) WIFE of Nicholas Fenlstich

6 DATE OF BIRTH (month, day, and year) May 24 1858

7 AGE Years 71 Months 10 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prussia

PARENTS

10 NAME OF FATHER Peter Schuchart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Katherine Fenlstich

(Address) 1917 Lafayette Ave

15 Filed MAR 28 1930, 19 H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 19 29 to March 26, 19 30

that I last saw h~~e~~ alive on March 25, 19 30

and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) 0 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Kool, M. D.

3/26 19 30 (Address) 413 N. Washington

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Mar 31 1930

20 UNDERTAKER John Ullrich — ADDRESS 200 S. Bl[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

55536

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 55536

CERTIFICATE OF DEATH

1—PLACE OF DEATH Md. General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Eser

(a) RESIDENCE NO. 216 S. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/14/30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Melvin Harris

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto

12 MAIDEN NAME OF MOTHER Minerva Eser

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Hospital record
(Address)

15 Filed APR 28 1930 C. HAMPSON JONES, M. D.
By R. Pyle Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/30

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 1930, to 3/25, 1930, that I last saw h[illegible] alive on 3/25, 1930 and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Premature Baby (6 mo)

(duration) 1 yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

3/25/30 (Address) Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hosp

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

IMPORTANT—Before signing, read carefully and answer all questions that apply. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55537 — 101-001 — E 55537

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Lillian Kemp

(a) RESIDENCE NO. 2633 Barclay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of William J. Kemp

6 DATE OF BIRTH (month, day, and year) Feb 10-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50 yrs.	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo. Rauch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie C. Kurtz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Galtz Md

14 Informant Hospital Records
(Address)

15 Filed ... 19 ... C. HAMILTON JONES, M.D. Registrar

MAR 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26-30

17 I HEREBY CERTIFY, That I attended deceased from 3-25-30, 19..., to 3-26-30, 19..., that I last saw her alive on 3-26-30, 19..., and that death occurred, on the date stated above, at 1039 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. Dorsey Rauch M.D.

19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	March 29 1930
20 UNDERTAKER	ADDRESS
Henry Sander & Sons, Inc.	Baltimore St & Broadway

MAKE SURE BE CERTAIN SUPPLIED. NOTE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD BE CAREFUL IN FILLING OUT CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/1

E 55538

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3900 Cottage Ave ST. 15-58 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ervin Eisenberg

(a) RESIDENCE NO. 3900 Cottage Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Eisenberg

6 DATE OF BIRTH (month, day, and year) Nov 22-1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) 059

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Eisenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie Buckoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Eisenberg (Address) 3900 Cottage Ave

Filed MAR 29 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/30

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1930, to March, 1930, that I last saw him alive on March 24, 1930, and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Ch Pulmonary T.B.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wash D.C.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Dr. Thomaston, M. D.

3/27, 1930 (Address) 733 Argyle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale C

DATE OF BURIAL 3/28 1930

20 UNDERTAKER Jack Laws

ADDRESS 1439 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55539

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55539

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. 23-31 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gissentaner

(a) RESIDENCE NO. 918 Leadenhall st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27 26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John Gissentaner

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Frances ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address)

15 Filed MAR 28 1930 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930 to March 25, 1930, that I last saw him alive on March 25, 1930, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) [signature] M.D.

3-26-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro N.C. DATE OF BURIAL 3-28-1930

20 UNDERTAKER [signature] ADDRESS 916 Cathedral

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

42 5303 55540

117 E 55540

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hazel Caswell

(a) RESIDENCE NO. 2318 Riggs Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country) Md

PARENTS

10 NAME OF FATHER Le Roy Caswell

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Ida Fay

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26-1930

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to Mar 26, 1930,

that I last saw h.. alive on Mar 26 1930

and that death occurred, on the date stated above, at 7 10 a. m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix & peritonitis

(duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) none

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? 2318 Riggs Ave.

Did an operation precede death? Yes Date of 3-25-30

Was there an autopsy? Abdominal incision & drain

What test confirmed diagnosis? Autopsy findings

(Signed) J. Bickford, M. D.

3/26, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	March 1930
20 UNDERTAKER	ADDRESS
Frederick Lassahn & Son	Fullerton

MAKE ENTRY IN CAREFULLY SUPPLIED. ANY ERROR should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55541 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55541

100

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 E. Lafayette ave ST. 17-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Ermold

(a) RESIDENCE NO. 210 E. Lafayette ST., ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER John P. Ermold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Dietz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Katie Ermold (Address) 210 E. Lafayette ave

15 Filed MAR 28 1930 E. BRYAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1930, to Mar 27, 1930, that I last saw h alive on Mar 26, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? usual.

(Signed) J. Lobstein Ermold, M. D.

Mar 27 1930 (Address) 2945 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Mar 29 30

20 UNDERTAKER Frederick Lassahn & Sons — ADDRESS Fullerton

Spec.—1-30—M. & T.—250 Bks.

E 55542

HEALTH DEPARTMENT—CITY OF BALTIMORE

3/ E 55542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 5-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christine Bervine (Christine Baker Bervine)

(a) RESIDENCE NO. 1202 Jefferson st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Raymond Bervine

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18 19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Poland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... C. HUMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1930

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to March 25, 1930,

that I last saw her alive on March 25, 1930,

and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Jno. Ghrmold Jr., M. D.

3-25 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Mar 28, 1930
20 UNDERTAKER Chris. H. Johnson	ADDRESS 416 N. Caroline St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55543

CERTIFICATE OF DEATH.

55543

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 W. Fayette St.) (WARD) 19-27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sara Walsh,

(a) RESIDENCE. NO. 1720 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W Walsh

6 DATE OF BIRTH (month, day, and year): Dec 31 1852

7 AGE — Years: 77 — Months: 3 — Days: 26 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter McSweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Brady
(Address) 1720 W Fayette st

15 Filed: MAR 28 1930 — C. HAMPSON JONES, M. D., Registrar — By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1930 to March 26, 1930 that I last saw h alive on March 26, 1930 and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Paralysis.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) J. O. Sawyer, M. D.

, 19 (Address) 904 N. Charles Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mercy Cathedral — DATE OF BURIAL: Mar 29 19 30

20 UNDERTAKER: John Feldt — ADDRESS: 200 W Lombard

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55544

CERTIFICATE OF DEATH

E 55544

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital (St.) 17-24 (Ward) 101

2-FULL NAME James H. Shelbert

(a) RESIDENCE NO. 1111 Fulton Alley (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
male	Colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Hopewell

6 DATE OF BIRTH (month, day, and year) April 1, 1889

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
40	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O+O
(c) Name of employer

9 BIRTHPLACE (city or town) St Mary Co.
(State or country) Md

PARENTS

10 NAME OF FATHER Benedict Hopewell

11 BIRTHPLACE OF FATHER (city or town) St Mary Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Carroll

13 BIRTHPLACE OF MOTHER (city or town) St Mary Co
(State or country) Md.

14 Informant Eliza Hopewell
(Address) Phila, Pa.

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pt Paralysis

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What tests confirmed diagnosis? —

(Signed) E. Ro Shadd M. D.

May 28, 19 30 (Address) 130 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 28 1930
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	3221 Schroeder St

Spec.—1-30—M. & T.—250 Bks.

E 55545

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55545

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3916 Harrison Blvd St. 15-63 WARD

2-FULL NAME George Weed Morris.

(a) RESIDENCE NO. 3916 Harrison Blvd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

2-REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie S. Morris.

6 DATE OF BIRTH (month, day, and year) Aug 1, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cattle Buyer 45

(b) General nature of industry, business, or establishment in which employed (or employer) D. B. Martin Co.

(c) Name of employer Retired 2 yrs.

9 BIRTHPLACE (city or town) St. Louis

(State or country) Mo.

PARENTS

10 NAME OF FATHER Thomas Morris.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Weed.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England.

14 Informant Mr. Calvin Sam Morris.

(Address) 3916 Harrison Blvd.

15 Filed MAR 28 1930, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26/930

17

I HEREBY CERTIFY, That I attended deceased from Jan 29th, 1925, to Mar 26th 1930

that I last saw h[illegible] alive on Mar 26th 1930

and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Boulton M.D. M. D.

3/27 1930 (Address) 3909 Harrison Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Mar 29, 30
20 UNDERTAKER	ADDRESS
Wm J Tucker & Sons	North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55546

CERTIFICATE OF DEATH.

90 ✓ E. 55546

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balt. Genl Hosp ST. 6-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Strew Trott.

(a) RESIDENCE NO. 1712 Mulliken ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Troutt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Ricourt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant J. N. Marshall

(Address) St. Inigoes Md

15 Filed MAR 28 1930, R&YC, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-1930

17 I HEREBY CERTIFY, That I attended deceased from 3-10-1930 to 3-27-1930, that I last saw him alive on 3-27-1930 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH was as follows: (1) Pneumatic Valvular Disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. Hesse, M. D.

1930 (Address) West Balto Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkridge Md — DATE OF BURIAL 3/28/1930

20 UNDERTAKER: Samuel I. Hemsley — ADDRESS 578 N. Eutaw

MARYLAND HISTORICAL SOCIETY

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55547

CERTIFICATE OF DEATH

74-001

E 55547

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Providence Hosp. (St.) 14-59 (Ward)

2-FULL NAME Lillie Wallace

(a) RESIDENCE NO. 220 Division St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col.	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day and year) Dec 24 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Leo Wallace

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Matthews

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Henrietta Matthews
(Address) 534 Lemmon

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Coroner, autopsy or inquiry) find that said deceased came to (her) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Sudden
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Hal Leith, M. D.

Mar 25 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Mar 28 1930

20 UNDERTAKER Mrs. Ida Snowden

ADDRESS 1705 E. Madison St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 8 1930 C. HERBERT JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55548 — 117 ✓ — E 55548

CERTIFICATE OF DEATH

1—PLACE OF DEATH Maryland General Hosp. REGISTERED NO. 15-67

CITY OF BALTIMORE: (No. Howard & Madison ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs William Zimmerman

(a) RESIDENCE NO. 360 E Edgewood Rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose M. Zimmerman

6 DATE OF BIRTH (month, day, and year) Dec 2-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 66

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robt. Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary Jasorcki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp Record
(Address)

15 Filed MAR 28 1930 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 19, 1930, to Mar 28, 1930, that I last saw him alive on Mar 28, 1930, and that death occurred, on the date stated above, at 6 15 a. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Coronary Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Mar 20-1930

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H C Reisenweber, M. D.

3/28, 1930 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL Mar 31 1930

20 UNDERTAKER Chas. B. Evans & Son — ADDRESS 118 W Mt Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55549

CERTIFICATE OF DEATH.

90 E 5.5549

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 116 N Paca ST. (WARD) 11-25

2-FULL NAME George Phillips

(a) RESIDENCE No. 116 N Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 50 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supt. 086

(b) General nature of industry, business, or establishment in which employed (or employer): Soap Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Linton H Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ky.

12 MAIDEN NAME OF MOTHER: Sola Yaple

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Geo Phillips

(Address): 116 N Paca St

15. Filed MAR 26 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 27 1930

17

I HEREBY CERTIFY, That I attended deceased from March 22 1930, to March 27 1930,

that I last saw him alive on March 26, 1930,

and that death occurred, on the date stated above, at 2. A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Aortic Heart Disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. A. O'neill M. D.

3/27, 1930 (Address) 108 N Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D C — DATE OF BURIAL: 3/28/30

20 UNDERTAKER: J. Adrens & Co — ADDRESS: R D Road 248 E

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55550

CERTIFICATE OF DEATH.

E 55550

117

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver St. 26-38 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Caretti

(a) RESIDENCE NO. 2500 Bowley's Lane WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 Yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucia Caretti

6 DATE OF BIRTH (month, day, and year) Apr

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Wife

(Address) 2500 Bowleys Lane

15 Filed MAR 28 1930 Registrar

C. HAMPSON JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1930

17

I HEREBY CERTIFY, That I attended deceased from March 22 1930 to March 27 1930

that I last saw him alive on March 27 1930

and that death occurred, on the date stated above, at 1 40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of March 22, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M M Woodruff, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Mar 29 1930

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Fremont Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 28 1930

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55551

CERTIFICATE OF DEATH

31 E 55551

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 36-37 Ward)

2-FULL NAME Charles Thorne

(a) RESIDENCE NO. Mpsurrn St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 087
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 [illegible] 19 C. HAMPSON JONES, M. D.
26 1930 1193 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cut T.B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Pathological

What pathological confirmed diagnosis?

(Signed) F. W. Coates, M. D.

19 (Address) 1432 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAN	MAR 2[illegible] 19 1930
20 UNDERTAKER (Commissioner Health.)	ADDRESS

H—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55552

CERTIFICATE OF DEATH

74-001 E 55552

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 W Hamburg ST. 21-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate A Wilbur

(a) RESIDENCE NO. 621 W Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed or divorced HUSBAND of (or) WIFE of Gustavus P Wilbur

6 DATE OF BIRTH (month, day, and year) Dec 4 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Daniel Knepp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary E Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mary E Forcier

(Address) 621 W Hamburg

15 Filed ... 19 ... By ... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27-1930

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to March 27, 1930, that I last saw h alive on March 24, 19, and that death occurred, on the date stated above, at 7 15 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? head

3/28, 1930 (Signed) [signature], M. D.

(Address) 547 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 3-29th 1930

20 UNDERTAKER Bernard C Harle

ADDRESS 1000 Pace St

R 2 8 1930

Be DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55553

CERTIFICATE OF DEATH

90 E 55553

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1529 Eutaw Place St., 14-20 Ward)

2-FULL NAME Alice Woody Byard

(a) RESIDENCE NO. 1529 Eutaw Pl. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edwin Rucks

6 DATE OF BIRTH (month, day and year): 1838

7 AGE: Years 87 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town):
(State or country)

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town):
(State or country)

14 Informant: Jas Mc Hugh
(Address) 522 Hamilton Ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Mar 27 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westview Cemetery — DATE OF BURIAL: Mar 29 1930

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

Spec.—1-30—M. & T.—250 Bks.

E 55554

HEALTH DEPARTMENT—CITY OF BALTIMORE

36-083 E 55554

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (TB.)

CITY OF BALTIMORE: (No. 18-29 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Love

(a) RESIDENCE NO. 818 Clifford st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 6, 1917 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Love

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Carried Green

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MAR 28 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 25, 1930, to March 25, 1930,

that I last saw him alive on March 25, 1930,

and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jos. Ghriveld Jr. M. D.

3-26, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL Mch 29th 1930

20 UNDERTAKER A. Jones ADDRESS W. S. Edmondson

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002

E 55555

REGISTERED NO. E 55555

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 N Woodington Ave WARD) 28-71

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret S. Smith

(a) RESIDENCE NO. 3 N Woodington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Smith Sr

6 DATE OF BIRTH (month, day, and year) Dec 25 1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
58	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Enoch J Batterden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry A Smith

(Address) 3 N Woodington Ave

15 Filed MAR 28 1930 By C. HAMILTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1930, to March 26, 1930

that I last saw h alive on March 26, 1930

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows: Cerebral Embolism, Cardiac Hypertrophy Angina

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. 2 mos. 8 ds.

18 Where was disease contracted if not at place of death? No Date of

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and Course

(Signed) James R Waterbury M. D.

3/28, 1930 (Address) 1729 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 3/29/30

20 UNDERTAKER George A Straley

ADDRESS Fulton & Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55556 90 E 55556

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 N. Wolfe ST. 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Antonio Porreco

(a) RESIDENCE NO. 202 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced — (or) WIFE of: Rose Porreco

6 DATE OF BIRTH (month, day, and year): Feb. 5, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Sewer work

(c) Name of employer: City of Balto

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Genaro Porreco

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: ———

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Mrs. Rose Porreco

(Address) 202 N. Wolfe St

15 Filed ..., 19... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1928, to March 26, 1930, that I last saw h[illegible] alive on March 26, 1930 and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Chr. Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac decompensation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Israel Feinglas, M. D.

3/27, 1930 (Address) 700 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: March 29, 193

20 UNDERTAKER: Frank V. Pipitone

ADDRESS: 2818 E, Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

R[illegible] 8 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 55557

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55557

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 S Madeira ST., 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maryanna Waligorska

(a) RESIDENCE NO. 206 S Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28-30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work -

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Ruthenie Waligorski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Walina Pryntka

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant A. Waligorski
(Address) 206 S Madeira

15 Filed APR 28 1930, 19 Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28. 30

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to March 28, 1930,

that I last saw her alive on March 28, 1930

and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Acute Colitis

(duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rydzewski M. D.

(Address) 8042 Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	March 29 1930

20 UNDERTAKER J. W. Bozewski 1980 ADDRESS Eastern

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55558

CERTIFICATE OF DEATH

57 E 55558

1—PLACE OF DEATH
CITY OF BALTIMORE. (No.) South Baltimore Gen. Hospital St. Ward
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Catherine Kulwicka

(a) RESIDENCE NO. 1917 Bank ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Bernard

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	If LESS than 1 day, ...hrs. or ....min.
52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS
10 NAME OF FATHER Mr Kwoon
11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.
12 MAIDEN NAME OF MOTHER unk.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant B Kulwicky
(Address) 1917 Bank St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-30

17 I HEREBY CERTIFY, That I attended deceased from 3-23, 1930, to 3-27, 1930
that I last saw her alive on 3-27, 1930
and that death occurred, on the date stated above, at 1.55 a m.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.
CONTRIBUTORY (Secondary) Diabetis Mellitus
(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Data of
Was there an autopsy? no
What test confirmed diagnosis? Physical Signs.
(Signed) Joseph A. Lauck ditis M. D.
(Address) South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	March 31 1930
20 UNDERTAKER	ADDRESS
J W Zozowski 1930	Eastern Av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

C. HUBSON JONES, M.

APR 2 8 1930

PRR

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55559

CERTIFICATE OF DEATH.

90 E 55559

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1711 E. 29 St., 9-4th Ward)

2-FULL NAME William H. Starr

(a) RESIDENCE NO. 1711 E. 29 St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary C. Starr

6 DATE OF BIRTH (month, day, and year): July 1836

7 AGE: Years 93 Months 9 Days 5 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co.

PARENTS

10 NAME OF FATHER: William H. Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary C. Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mr. Lee C. Starr

(Address) 1711 E. 29 St.

15 Filed 2 8 1930 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Valvular Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Torrance (Coroner) M. D.

3/27 1930 (Address) 3632 Orland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Cemetery Balto Co. Md. Date of Burial 3-29 1930

20 UNDERTAKER: A. S. Marshall ADDRESS 2539 Fall Road

Filed

Do not write above this line

If information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55560

CERTIFICATE OF DEATH

40E 55560

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 16-23 Ward)

2-FULL NAME Clara Bordley

(a) RESIDENCE NO. 1023 W. Lorey St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fmd	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt Bordley

6 DATE OF BIRTH (month, day, and year) Sept 14 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48	6	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Robt Bordley
(Address) 1023 W. Lorey St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 26. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (h
on the day stated above.
The CAUSE OF DEATH* was as follows:

General Peritonitis
and Congestion of Kidney
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 25th

Was there an autopsy? Yes Cut Later Examined

What test confirmed diagnosis? Regular

(Signed) J Bolton Smith, M. D.
May 26th (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL 3/29 1930

20 UNDERTAKER Thomas E. Kelson — ADDRESS 130 Preston St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55561 E 55561

CERTIFICATE OF DEATH

REGISTERED NO. 74001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augustus Gray

(a) RESIDENCE NO. 1422 N. Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florance Gray

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Margaretta Sullivian

(Address) 1422 N. Gilmore

15 Filed MAR 28 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-30

17

I HEREBY CERTIFY, That I attended deceased from 3-25-30, 19, to March 27, 1930, that I last saw h alive on March 27, 1930 and that death occurred, on the date stated above, at 3 00 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mon. 7 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 3/29 1930

20 UNDERTAKER Thomas E. Kelson.

ADDRESS 1302 Pennsylvania Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55562

CERTIFICATE OF DEATH

23 E 55562

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 129. Warren Ave. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Sundi

(a) RESIDENCE NO. 129. Warren Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Sundi

6 DATE OF BIRTH (month, day, and year) Dec 31-1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
34	2	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Fruit Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER August Sundi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carolina Lombardi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Carolina Sundi

(Address) 129. Warren ave

15 Filed MAR 29 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 15 1930 to Mar 27 1930

that I last saw ~~was~~ alive on Mar 26 1930

and that death occurred, on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (duration) yrs. mos. ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Mar 31 1930

UNDERTAKER Fred A. Kahnke & Son

ADDRESS 703 E Hamburg St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 55563

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 92 ✓ E 55563

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Jail St. 26-37 Ward)

2-FULL NAME Orville D. Denny

(a) RESIDENCE NO. 507 E. st. Sparrows Point Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed or divorced~~ HUSBAND of ~~(or) WIFE of~~ Helen Denny

6 DATE OF BIRTH (month, day, and year) 1/05/98

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
32	2	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) Building
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Kansas

PARENTS

10 NAME OF FATHER John Denny

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Runa.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Helen Denny
(Address) 325 Granick st Harrisburg Pa

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Hardening of Epilepsy

duration yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~Hardening~~ ~~Epilepsy~~ Jail Coroner's ~~Epilepsy~~ Epilepsy

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Riley, M. D.

March 26, 1930 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	3/29/1930
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul st

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55564

E 55564

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Mercy Hosp — REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. _____ ST. 28-64 WARD _____

2-FULL NAME Olivia Bayliss

(a) RESIDENCE NO. 450 Wentworth Rd ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

6 If married, ~~widowed, or divorced~~ ~~Husband~~ of or) WIFE of Alexander P. Bayliss

6 DATE OF BIRTH (month, day, and year) 3/5/1857

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	73	0	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) At Home 37
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS
10 NAME OF FATHER John T. Winder
11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.
12 MAIDEN NAME OF MOTHER Sarah A Winder
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Bunch (Address)

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/30

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1930, to 3-28, 1930, that I last saw her alive on 3-26, 1930, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis with rupture
(duration) _____ yrs. _____ mos _____ ds.

CONTRIBUTORY (Secondary) Chr Nephritis & Arteriosclerosis
(duration) _____ yrs. _____ mos. 7 ds.

18 Where was disease contracted if not at place of death? _____
Did an operation precede death? Yes Date of 3/25/30
Was there an autopsy? No
What test confirmed diagnosis? Clinical & operative

(Signed) J Taylor M. D.
3/25, 19 30 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem — DATE OF BURIAL 3/31/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

R 29 1930 C. HAMPSON JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E. 55565 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E. 55565

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 Winston Ave. ST. 27-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Ann Merrill

(a) RESIDENCE NO. 812 Winston Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 16, 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	98	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Moses Merrill

11 BIRTHPLACE OF FATHER (city or town) Falmouth (State or country) Maine

12 MAIDEN NAME OF MOTHER Catherine Ann McClatchie

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Miss Anne C. Meushaw

(Address) 812 Winston Ave.

15 Filed MAR 29 1930, 19 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 26, 1930, to P.M Mch 26, 1930, 8.30 P.M Mch 26, 1930, that I last saw h er alive on Mch 26, 1930, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Probable Pneumonia

Such old page had about done its work.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) nearly 99 years (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

Mch 27, 1930 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL March 29, 1930

20 UNDERTAKER Robert B Cook

ADDRESS 1003 West Baltimore St.

Important. See instructions on back of certificates.

Cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

Spec.—8-16-29—L. F. S.—100 Bks.

E 55566

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 55566

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3437 Mondawmin St. 15-6 WARD)

2—FULL NAME Mrs Mary Rose Zellers

(a) RESIDENCE NO. 3432 Mondawmin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of John Zeller

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Harrisburg (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James Shorter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rose Farley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Samuel Zeller

(Address) 3437 Mondawmin Ave

15 Filed MAR 29 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28/30

17 I HEREBY CERTIFY, That I attended deceased from March 2d, 1930, to March 28, 1930, that I last saw her alive on March 27th, 1930 and that death occurred, on the date stated above, at 12.50 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Amelia E Little, M. D.

3/25, 1930 (Address) 1717 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Druid Ridge

DATE OF BURIAL MAR 31 1930

ADDRESS 2700 EDMONDSON AVE.

D. UNDERTAKER Geo W Little

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55567

CERTIFICATE OF DEATH

74 E 55567

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 8-17 Ward)

2-FULL NAME Bertha a. Scheper

(a) RESIDENCE NO. 1515 N. Register St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Scheper

6 DATE OF BIRTH (month, day, and year) Feb 29/1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	78	0	28 29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Henry Hilker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhemina Buschman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Henry Scheper
(Address) 1515 N. Register St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

R 2 9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy (Fell in home)

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Fractured left neck of femur (3/10/30) Result of Apoplexy (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Cast Date of Mch 27/30

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X ray

(Signed) [illegible] M. D.

3/28/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	March 31 1930
20 UNDERTAKER	ADDRESS
Henry Koch Sons Inc.	1301 E Eager

Spec.—8-16-29—L. F. S.—100 Bks.

E 55568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74001

E 55568

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andy Moore

(a) RESIDENCE NO. 1435 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Moore

6 DATE OF BIRTH (month, day, and year) Oct. 18, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town) [redacted]

(State or country) Charlotte N. C

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Mary (P)

13 BIRTHPLACE OF MOTHER (city or town) Charlotte

(State or country) N C

14 Informant Mary Moore

(Address) 1435 E. Fayette St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

R 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-30

17

I HEREBY CERTIFY, That I attended deceased from Jan 15 1930, to March 27, 1930, that I last saw h.im alive on March 27, 1930 and that death occurred, on the date stated above, at 8 00 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arterial Sclerosis

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY Arterial Sclerosis

(Secondary)

(Hypertension) (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical + Autopsy

(Signed) Camille M. St Cyr, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlotte N.C. Woodlawn Cemetery

DATE OF BURIAL March 29 1930

20 UNDERTAKER Edward Bozan

ADDRESS 1681 Orleans St

Sex of person is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55569

E 55569

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE; (No. 415 Tuxedo ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Zeller

(a) RESIDENCE NO. 415 Tuxedo ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alverta Zeller

6 DATE OF BIRTH (month, day, and year) May 4-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work Stationary Fireman

(b) General natore of industry, business, or establishment in whirh employed (or employer)

(r) Nsme of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER John Zeller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Lutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Alverta Zeller

(Address) 415 Tuxedo St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1930, to March 27, 1930, that I last saw him alive on March 25, 1930 and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Stomach)

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Operation (Union Memorial)

(Signed) Chas R. Goodwin, M. D.

, 19 (Address) 3923 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Smallwood Lutheran Cem.	March 30, 1930.
20 UNDERTAKER Carroll Co. Md.	ADDRESS
Horace H. Burgee	3631 Falls Road

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55570

1—PLACE OF DEATH — Brooklyn 46 — REGISTERED NO. 75-75

CITY OF BALTIMORE: (No. 3573 Fourth St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Seward L Coulbourn

(a) RESIDENCE NO. 3573 Fourth ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of Lydie E Coulbourn

6 DATE OF BIRTH (month, day, and year) April 23 1866

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Carpenter 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Curtis Bay Md

PARENTS

10 NAME OF FATHER Stephen C Coulbourn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Reddish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Addie N Donaldson

(Address) 3723 S. Fifth st

15 Filed 3-29-1930 — G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1929, to March 26, 1930

that I last saw h[illegible] alive on March 26, 1930

and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face and mouth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dr Loustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of about 1 yr ago

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brosius, M. D.

3/27, 1930 (Address) 3601 Third Street

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 3/29 1930

20 UNDERTAKER J. F Denny — ADDRESS 715 Light St

R 2 9 1930

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55571

CERTIFICATE OF DEATH

80 ✓ E 55571

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 2811 Christopher ST., 27-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Cossentino

(a) RESIDENCE NO. 2811 Christopher Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. 12 How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 1930

7 AGE — Years: — Months: — Days: 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Cossentino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Marie Lavezza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary Lavezza

(Address) 2908 Franklin ave

15 Filed MAR 29 1930, 19 ..... R. C. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29-30

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1930, to March 28, 1930, that I last saw h[illegible] alive on March 28, 1930 and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

..... (duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Interstat Columbia

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Valentine M. D.

March 29 1930 (Address) 1 E Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincent — DATE OF BURIAL: March 29 1930

20 UNDERTAKER: Frank V. Pikitone — ADDRESS: 2518 E. Balto St

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

esc John Keene

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55572

E 55572

CERTIFICATE OF DEATH

X 129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Keene

(a) RESIDENCE NO. 1512 N Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Keene

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 68

(c) Name of employer

9 BIRTHPLACE (city or town) Madison (State or country) Md

PARENTS

10 NAME OF FATHER Henry Keene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Smithin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Keene (son)

(Address) 1512 N Dallas

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

R 2 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-30

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to March 27, 1930, that I last saw h[illegible] alive on March 27, 1930 and that death occurred, on the date stated above, at 4 00 a.m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular - Renal

Disease

(duration) about 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contrartrd if not at place of death?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Carroll M. Stokes, M. D.

19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	3/29/30
20 UNDERTAKER	ADDRESS
Robert W. Williams	1515 W. Lexington St

Important. See instructions on back of certificates. Exact statement of OCCUPATION is necessary. Use ink or pencil in plain terms, so that it may be properly classified.

Spec.—1-12-23—M&T—500 Blks.

E 55573 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55573

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014-E. Lanvale ST.) 8-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Steigers

(a) RESIDENCE NO. 2014-E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. E. Steigers

6 DATE OF BIRTH (month, day, and year) 8-8-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Bissitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant (Mrs. M. Steigers) (Address) 2014-E Lanvale St.

15 Filed MAR 29 1930, 19 C. HAMPTON ROBERTS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1930

17 I HEREBY CERTIFY, That I attended deceased from March 20 1930 to March 28 1930

that I last saw h[illegible] alive on March 28 1930

and that death occurred, on the date stated above, at 3:0 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Hemiplegia L of Rt. side

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tonry M. D.

3-28 1930 (Address) 414 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 3/31/30 19

20 UNDERTAKER Mary T. Pugh

ADDRESS 1235 Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55574

45 E 55574

CERTIFICATE OF DEATH

E 55574

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 574 University Parkway WARD) 12-49

2—FULL NAME Florence P. Watts

(a) RESIDENCE NO. Jonesport, Maine ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank H. Watts

6 DATE OF BIRTH (month, day, and year) Nov. 29, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maine

PARENTS

10 NAME OF FATHER Daniel Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rebecca Sawyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Mrs. Edward Beazley

(Address) 574 University Parkway

Filed MAR 29 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 13 1930, to Mar 28, 1930, that I last saw her alive on Mar 27, 1930 and that death occurred, on the date stated above, at 8.35 P. m.

The CAUSE OF DEATH* was as follows: Intestinal obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) neoplasm of intestines (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles H. Thompson M. D.

3/29, 1930 (Address) 928 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbia, Maine

DATE OF BURIAL Mar. 29 1930

20 UNDERTAKER Lowell B Cook

ADDRESS 1003 West Baltimore St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 55575 HEALTH DEPARTMENT—CITY OF BALTIMORE N 55575

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1925 W.e Henry ST. 20-28 WARD)

2-FULL NAME Georgeanna Shriner

(a) RESIDENCE NO. 1925 W.e Henry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A Shriner

6 DATE OF BIRTH (month, day, and year) Jan. 30-1850

7 AGE Years 60 Months 2 Days 27 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John A Grammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Georgeanna Pool

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Mrs. Harry D. Wholey 2607 Druid Hill Ave

15 Filed MAR 29 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 27, 1930, that I last saw her alive on March 27, 1930, and that death occurred, on the date stated above, at 3-30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse

Mitral Insufficiency Hypertrophy Arteriosclerosis

Chronic Interstitial Nephritis

Delerium (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norbert C Nickel M. D.

3/28/30 (Address) 2157 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL Mar. 29 1930

20 UNDERTAKER George L. Schwab ADDRESS 2101 Druid Park Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

29 1930

Spec.—2-29-28—L. F. S.—500 Bks.

E 55576

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 55576

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 Biddle ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Howard

(a) RESIDENCE NO. 739 Biddle WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 17 1883

7 AGE: Years 46 | Months 9 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Richard Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hutcoon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hutcoon

14 Informant: Mary E Howard
(Address) 739 Biddle St

15 Filed ..... 19 ..... Registrar

APR 2 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 26/30

17

I HEREBY CERTIFY, That I attended deceased from Mar 17, 1930, to Mar 26 1930

that I last saw him alive on Mar 25, 1930

and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Mary E. Dugent M. D.

3/28/1930 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 3/29/30

20 UNDERTAKER: Edward Hensley

ADDRESS 1078 Biddle

important. See instructions on back of certificates.

Spcg.—8-24-14—M. & T.—2000 Blks.

E 55577 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55577

CERTIFICATE OF DEATH.

65-002

15-6T

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3407 Duval Ct. St.; 15 Ward)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Agnes Helen Robbins

(Residence in Baltimore: No. 3407 Duval Ct. St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Married

6-DATE OF BIRTH, March 18, 1886 (Month) (Day) (Year)

7-AGE, 44 yrs. 0 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Palmer Concord N.H.

PARENTS.

10-NAME OF FATHER, Judge Robert A Ray

11-BIRTHPLACE OF FATHER (State or Country), New Hampshire

12-MAIDEN NAME OF MOTHER, Hattie A Sallow

13-BIRTHPLACE OF MOTHER (State or Country), Concord N.H.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred H. Robbins

(Address) 3407 Duval Ct.

15-

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March 28, 1930. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1927, to Mar 28 1930, that I saw h alive on Mar 28 1930, and that death occurred, on the date stated above, at 11.30 p.m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(Duration) 3 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(Duration) yrs. 3 mos. ds.

(Signed) Howard H. Warner M. D.

Mar 28, 1930. (Address) 360 Garrison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Concord N.H. DATE OF BURIAL, Mch 30, 1930.

20-UNDERTAKER, Thos J. Freeman & Bro ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

MAR 29 1930 C. HAMPDEN JOHNS, M.D.

Spec.—1-30—M.&T.—250 Bks.

E 55578

E 55578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1139 (St.) Washington Blvd (WARD) 21-29

2-FULL NAME John Henry Cain Sr.

(a) RESIDENCE NO. 1139 (St.) Washington Blvd (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 5 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma A. Cain.

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Engineer.

(b) General nature of industry, business, or establishment in which employed (or employer) B & O. 03

(c) Name of employer Retired.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm Cain.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hildebrand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant John Henry Cain Jr.

(Address) 1139 Washington Blvd

15 Filed MAR 29 1930, 19 C. HAMILTON BOOTH, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27, 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-1-, 19 30, to 3-27-, 19 30,

that I last saw h[e] alive on 3-27, 19 30

and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency 3 days

growth in neck of bladder

possible (Cancerous)

(duration) yrs. mos 3 ds

with Uremia,

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signature Howard Dorsey, M. D.

19 Address 1127 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Mar. 31, 1930
20 UNDERTAKER Wm Mackert Sons	ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55579

CERTIFICATE OF DEATH.

101-08

E 55579

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1075 W Fayette ST. 18-26 (WARD)

2-FULL NAME Dorothy Booker

(a) RESIDENCE NO. 1075 W Fayette ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Blk	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 21st 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER Robin Booker

11 BIRTHPLACE OF FATHER (City or town) Clarendon Co (State or country) Va

12 MAIDEN NAME OF MOTHER Elsie Wood

13 BIRTHPLACE OF MOTHER (City or town) Lancaster Co (State or country) Va

14 Informant Robin Booker
(Address) 1075 W Fayette

15 Filed MAR 9 1930, 19 .....

C. HARRISON JONES, Registrar

RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/19, 1930, to 3/27, 1930, that I last saw her alive on 3/26, 1930, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 15 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustav Todtman, M. D.

, 19 (Address) 1516 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Mar 29, 1930
20 UNDERTAKER	ADDRESS 3221 Schroeder St.
Mrs. Katie R. Williams	

CROSS OUT DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAU... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55580

CERTIFICATE OF DEATH

86 Vol. E 55580

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 752 Bradley St., 17-76

2-FULL NAME Bernice McBride

(a) RESIDENCE NO. 752 Bradley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not

6 DATE OF BIRTH (month, day, and year) Aug 3-1928

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Frankie McBride

11 BIRTHPLACE OF FATHER (city or town) W. Va
(State or country)

12 MAIDEN NAME OF MOTHER Mabel Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Frankie McBride
(Address) 752 Bradley

15 Filed ..... 19.... C. THOMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Mar 26th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death by the means stated below, on the day stated above.

The CAUSE OF DEATH* was as follows:

Otis Media

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) A. Schmitt, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL March 27, 1930

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 332 N. Schroeder St

R29 1530

Spec.—2-29-28—L. F. S.—500 Bks.

E 55581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 55581

REGISTERED NO. 16-23

1—PLACE OF DEATH 708 n. Stockton St

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alfred Garfield Fulley,

(a) RESIDENCE NO. 708 N. Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... da. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Infant,

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			14.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto. (State or country) Md,

PARENTS

10 NAME OF FATHER William R. Fulley

11 BIRTHPLACE OF FATHER (city or town) Annapolis, (State or country) Md.

12 MAIDEN NAME OF MOTHER Willmette Mc Kendall

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia

14 Informant The Father

(Address) 708 N. Stockton

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES M. D.

2 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/30

17 I HEREBY CERTIFY, That I attended deceased from March 12th, 1930, to March 26, 1930, that I last saw h.. alive on March 26th 1930 and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum,

(duration) ..... yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Improper diet or poor Mothers milk, (duration) ..... yrs. ..... mos 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical Diagnosis

(Signed) J. T. Gunn, M. D.

19 (Address) 522 N. Carlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL Mar. 29, 1930

20 UNDERTAKER Mr. Katie P. Williams

ADDRESS 327 Schroeder St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—$00 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55582

CERTIFICATE OF DEATH

46 ✓ E 55582

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1634 Ellamour ST., 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Juliette Leharles Thomason

(a) RESIDENCE NO. 1634 Ellamour ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 10-1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Henry Charles.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Catherine Clafh.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Miss Lida L. Thomason

(Address) 1634 Ellamour ave

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

R 29 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 6th, 1929, to Mar. 27-, 1930, that I last saw her alive on Mar. 27-, 1930 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 1928

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Isaac A Dickson, M. D.

Mar 28, 1930 (Address) 3055 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL Mar 31 1930

20 UNDERTAKER George J Smith

ADDRESS Hollins

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55583

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55583

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. W-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Anna G. Hunt

(a) RESIDENCE NO. 15 E. Joppa Road ST. Towson ~~WARD~~ Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

6a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: William Hunt

6 DATE OF BIRTH (month, day, and year): Sept 2 1871

7 AGE: Years 59 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore County Md

PARENTS

10 NAME OF FATHER: John Beatty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Olive

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wm G Hunt
(Address) 15 E Joppa Rd Towson Md

15 Filed ... 19 ... Registrar

(C. HAMPSON JONES, M. D.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 25, 1930, to Mar. 28, 1930, that I last saw her alive on Mar. 28, 1930 and that death occurred, on the date stated above, at 5 20 A.m.

The CAUSE OF DEATH* was as follows:

Broncho. pneumonia

(duration) ... yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

Hypertension (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George H. Yeager, M. D.

3/28, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cylmalira Cemetery My Lady Manor Balto Co

DATE OF BURIAL: March 30 1930

20 UNDERTAKER: E. George J. Smith

ADDRESS 153 Hollins

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55584

CERTIFICATE OF DEATH.

REGISTERED NO. 161-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp STREET 6-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Souter

(a) RESIDENCE No. 2873 Oliver Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-19-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary land

PARENTS

10 NAME OF FATHER William Souter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Elsie Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Hospital record (Address)

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

29 1930 1494

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24-30

17 I HEREBY CERTIFY, That I attended deceased from 3-19, 1930, to 3-24, 1930, that I last saw h— alive on 3-24, 1930, and that death occurred, on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

over

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

3-25 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

MAR 29 1930

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 55585

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55585

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Hanover St. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Bongiovani

(a) RESIDENCE No 1019 Hanover ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Nellie Castagnetti

6 DATE OF BIRTH (month, day, and year) 11/14-1886

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Benedetto Bongiovani

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Libertini

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Nellie Bongiovani

(Address) 1019 Hanover St.

15 Filed MAR 29 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1930

17

I HEREBY CERTIFY, That I attended deceased from Jan 14, 1929, to March 27, 1930, that I last saw him alive on March 24, 1930, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1/4/30

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Wilhelm Fort, M. D.

3/29, 1930 (Address) 20 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 3/31 1930

20 UNDERTAKER Mary T. Rutt

ADDRESS 1135 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 55586 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓E 55586

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723. Jefferson St. 6-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Cohen

(a) RESIDENCE NO. 1723 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 68 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Solomon Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Minnie Blum

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jane Cohen

(Address) 2102 Pimlico Rd.

15 Filed MAR 30 1930 HAMPSON [illegible], M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1930

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1930, to March 28, 1930, that I last saw h(e) alive on March 28, 1930, and that death occurred, on the date stated above, at 1:10 P m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Zinberg M. D.

3/28 1930 (Address) 2220 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run

DATE OF BURIAL: 3/30 1930

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 112 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Horowitz ✓ B 55587

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 55587

CERTIFICATE OF DEATH.

90 F 55587

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument & Rutland ST. 14 (WARD)

2-FULL NAME Mr. Jacob Horowitz

(a) RESIDENCE NO. 1817 Eutaw Pl ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced (or) WIFE of: Late Hannah Ada

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 72 — Months — Days — If LESS than 1 day, ... hrs. or ... min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Chaim David Horowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Mr. Horowitz 1817 Eutaw Pl.

15 Filed ... 19 ... C. HAMPTON JONES, M. D. Registrar

MAR 30 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/29 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/13, 1930, to 3/29, 1930, that I last saw h/ alive on 3/29, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation - left sided.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): chr. myocarditis.

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at sinai hospital

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) A. A. Silver M. D.

3/29 1930 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sinai Washington Rd

DATE OF BURIAL: 3/30 1930

20 UNDERTAKER: Hof Levinson & Bro

ADDRESS 1127 E Balto st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

William H. Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

55588

E 55588

CERTIFICATE OF DEATH

31

E 55588

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1102 E Biddle St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Smith,

(a) RESIDENCE NO. 1102 E. Biddle St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 8 mos. 11 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 19—1896

7 AGE: Years 33 Months 8 Days 11 IF LESS than 1 day ...hrs. or ...min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer): 061

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Louis Smith

11 BIRTHPLACE OF FATHER (City or town): Baltimore Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Wm. A. Heltzel

(Address) 1102 E Biddle St

15 Filed ... C. HAMPSON JONES, M. Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: March 28, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to March 28, 1930, that I last saw h... alive on March 28, 1930, and that death occurred, on the date stated above, at 7.15 m.

The CAUSE OF DEATH* was as follows:

I. Acute Pulmonary Tuberculosis

(duration) ... yrs. 5 mos. ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms Etc

(Signed) ... M. D.

3/29, 19 30 (Address) 888 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

Date of Burial: March 31 1930

20 UNDERTAKER: Mc-Mes & S. Frank

ADDRESS 2512 N. Howard

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JAN 30 1930

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55589

CERTIFICATE OF DEATH.

E 55589
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Nonument St. (Ward) 14-20 101-001

2-FULL NAME Max Gucharsky

(a) RESIDENCE NO. 2129 Breton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of):

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Rag Dealer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

045

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Balto

15 Filed MAR 30 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/30 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to March 30, 1930, that I last saw him alive on March 30, 1930, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary): Chronic myocarditis arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical tests

3/30 1930 (Signed) J. H. Conn M. D.
(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Kehilath Rosedale — DATE OF BURIAL: 3/30 1930

20 UNDERTAKER: Jack Lewis 1439 E Balto — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Gillian Hayden 84 ✓

E 55590 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 55590**

E 55590 CERTIFICATE OF DEATH REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No. Mt Grantop pr St. 25-7 WARD)

2—FULL NAME Mrs Lelia Hayden

(a) RESIDENCE NO. 2412 James ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. — mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write which)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eli Hayden

6 DATE OF BIRTH (month, day, and year) May 9 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) Childs

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Harry Offandel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Eliz Damer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Amy Hayden (Address) Hospital Road.

15 Filed MAR 30 1930 CLAMPON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28/30

17 I HEREBY CERTIFY, That I attended deceased from 2/21/30, 19..., to 3/28/30, 19..., that I last saw h.e alive on 3/28/30 9.25 p. m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

1 Coma

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home Date of 3/28/30

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 3/30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 3/31/30

20 UNDERTAKER Geo Lembach ADDRESS W Lombard

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-30—M. & T.—250 Bks.

E 55591 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55591

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. 2-4 ST. 31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Donovan

(a) RESIDENCE NO. 403 S. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Anna

6 DATE OF BIRTH (month, day, and year) Dec 11-1899

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	29	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Mone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hospital Records (Address)

15 Filed 19 Per Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28/30

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1930, to 3-28, 1930, that I last saw h[illegible] alive on 3-28, 1930, and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Peritonitis .2 days Pulmonary Tuberculosis 3 yrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-26-30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J Leyko, M. D.

3/28 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL 3/31 1930

UNDERTAKER William Fiaschetti 1611 Eastern

ADDRESS

CAUSE OF DEATH must be properly classified. STATE NATURE OF OCCUPATION. TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55592

111-001

E 55592

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonard Lawson

(a) RESIDENCE NO. 1715 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Lawson

6 DATE OF BIRTH (month, day, and year) July 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
39	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Geo Lawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Della Brank

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

13 Informant Gertrude Lawson

(Address) 1715 Madison Ave

3-30 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1930

17

I HEREBY CERTIFY, That I attended deceased from MARCH 14, 1930, to March 29, 1930, that I last saw h/m alive on March 29, 1930 and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

GASTRIC ULCER

(duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Secondary Hemorrhage (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of MARCH 18, 1930

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Pathological

(Signed) Samuel T. Stevens, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
Blandwell Wharf Co	Mar 30 30
20 UNDERTAKER	ADDRESS
Hammond Bellistri	700 N Caroline Ave

Grant. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Coroner Bladen by 7/30

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55593

CERTIFICATE OF DEATH

90

E 55593

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital C-17 Ward)

2-FULL NAME John H. Skillman

(a) RESIDENCE NO. 1618 N. Chapel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary A

6 DATE OF BIRTH (month, day, and year) Dec 6th 1865

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
64	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bricklayer
(b) General nature of industry, business, or establishment in which employed (or employer) Building
(c) Name of employer Self

9 BIRTHPLACE (city or town) .....
(State or country) Washington State

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Robert Skillman
(Address) 1618 Chapel St

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY Exhaustion (Secondary)

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) W. J. C. Bladen, M. D.

, 19 (Address) 4376 Bonny

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	3/31/30
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

Dr Duane
Washington Blvd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55594

CERTIFICATE OF DEATH.

90

E 55594

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3226 Viona Ave ST 25-24 WARD)

2-FULL NAME Jessie M. Lee

(a) RESIDENCE NO. 3226 Viona Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Lee

6 DATE OF BIRTH (month, day, and year) June 19, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	25	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William J. Rourkelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Mary Rourkelly

(Address) 3226 Viona Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1929, to 3-28-1930, that I last saw h.. alive on 3-28-1930 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Dunn, M. D.

3/31/30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL Mar 31 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul

TION is very important. See instructions on back of certificate.

MAR 31 1930 C. HERMAN JONES, M.

Spec.—8-16-29—L. F. S.—100 Bks.

Dr Dean 1227 York Blvd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55595

CERTIFICATE OF DEATH

14-001 E 55595

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1262 Washington Blvd ST., 21-29 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles A Wallace

(a) RESIDENCE NO. 1262 Washington Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of Mary A Wallace

6 DATE OF BIRTH (month, day, and year) Feb 19 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Self 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Anna Sedeker

(Address) 1262 Washington Blvd

15 Filed MAR 30 1930 19 H. HARRY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 28. 1930

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to March 28, 1930, that I last saw h alive on 3/28/30, 19, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cystitis Arteriosclerosis

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Dean M. D.

(Address) 227 York Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 3/31 1930

20 UNDERTAKER J M Cook

ADDRESS 1212 E Pond Av

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks Dr. Michael Poplar Grove & Edmondson Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55596 — CERTIFICATE OF DEATH. — 101-001 — E 55596

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1736 Ashburton ST. (15-68 Ward)

2-FULL NAME Walter L. Willis

(a) RESIDENCE NO. 1736 Ashburton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or) WIFE of~~ Laura V. Willis

6 DATE OF BIRTH (month, day, and year) Aug 12th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	7	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of Industry, business, or establishment in which employed (or employer) Building 0 50
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Phila Pa

PARENTS

10 NAME OF FATHER William Willis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Laura V. Willis
(Address) 1736 Ashburton st.

Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29/30.

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to March 29, 1930, that I last saw him alive on March 29, 1930, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 7 ... ds.

CONTRIBUTORY (Secondary) Acute myocardial degen

(duration) ... yrs. ... mos. 2 ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D Wm Michael, M. D.

M 29 1930 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md — DATE OF BURIAL 4/1/30

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓

E 55597

E 55597

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 N. Lakewood ST., 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Kurdna

(a) RESIDENCE NO. 711 N. Lakewood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Frances Kurdna

6 DATE OF BIRTH (month, day, and year) Oct. 28. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bushelman.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Geo E. Harris & Co

9 BIRTHPLACE (city or town) Vienna.

(State or country) Austria.

PARENTS

10 NAME OF FATHER Frank Kurdna.

11 BIRTHPLACE OF FATHER (city or town) Vienna

(State or country) Austria

12 MAIDEN NAME OF MOTHER Kurdna

13 BIRTHPLACE OF MOTHER (city or town) Kurdna

(State or country)

14 Informant Mrs Frances Kurdna

(Address) 711 N. Lakewood

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1930, to March 28, 1930

that I last saw h~~im~~ alive on March 27, 1930

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Carcenoma Faryng

(duration) yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. Fa Stevens, M. D.

3/28, 1930 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Mar 31 1930

20 UNDERTAKER Robert Ulrich

ADDRESS 8008 Belair

Important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55598

49 E 55598

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 4509 Liberty Heights Ave St. Ward 26-6th

2-FULL NAME Mrs Bertha Ines Smink

(a) RESIDENCE NO. 4509 Liberty Heights Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. A. C. Smink

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	49	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Towson (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. W. Ines

11 BIRTHPLACE OF FATHER (City or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant A. C. Smink (Address) 4509 Liberty Heights Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29 1930

17 I HEREBY CERTIFY, That I attended deceased from 9/8, 1929, to 3/29, 1930, that I last saw her alive on 3/29, 1930, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pulmonary Oedema.

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Sarcoma Liver - following Sarcoma Eye about (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) J. J. Cahill, M. D.

3/29, 1930 (Address) 1117 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial Mar 31 1930

20 UNDERTAKER Harry N. Armacost ADDRESS 4204 Ridgewood Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

2 3 3 5 1

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55599

CERTIFICATE OF DEATH

37-002

E 55599

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME May Mitchell

(a) RESIDENCE NO. 522 N. Ashland ST., ST — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Zadie Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Parents —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 30 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25-30

17

I HEREBY CERTIFY, That I attended deceased from Mar. 26, 1930, to Mar. 25, 1930, that I last saw her alive on Mar. 25, 1930 and that death occurred, on the date stated above, at 2 15 P m.

The CAUSE OF DEATH* was as follows:

Acute generalized tuberculosis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J W Bickford, M. D.

3/29. 1930 (Address) J H H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemty

DATE OF BURIAL 3/31 1930

20 UNDERTAKER Byron Wright

ADDRESS 1219 N. Caldwell —

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55600

CERTIFICATE OF DEATH

18 E 55600

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St., 18-26 Ward)

2-FULL NAME Walter Howe.

(a) RESIDENCE NO. 920 W. Baltimore St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. —mos.—dys. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of ~~(or WIFE of)~~ Minnie L. Howe.

6 DATE OF BIRTH (month, day, and year) June 20, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	50	9	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shop Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer) Dietrich Bros.
(c) Name of employer

9 BIRTHPLACE (city or town) New York.
(State or country)

PARENTS

10 NAME OF FATHER Howe.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Martha Poe.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England.

14 Informant Mrs. Minerva Hall. (daughter)
(Address) 1569 Homestead St.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the neck of femur.
Occidental fall on ice.
Rheumatic Cardiac Valvular disease.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? 920 Pleasant St. January 22, 1930

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt M. D.

3/29, 1930 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 31 1930
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 30 1930 HARRISON JOURNAL INC.

Spec.—1 12-23—M&T—500 Bks.

E 55601

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 55601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Jenkins Memorial Hospital (Street) (Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard McMahon

(a) RESIDENCE NO. 1207 Valley ST., WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary McMahon (nee Connelly)

6 DATE OF BIRTH (month, day, and year) Mar. 11. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Driver

(c) Name of employer Balto City Water Dept

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Philip McMahon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary McMahon (wife)

(Address) 1207 Valley St.

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28 1930.

17 I HEREBY CERTIFY, That I attended deceased from 1-16, 1930, to 3-28, 1930, that I last saw h live on 3-28, 1930, and that death occurred, on the date stated above, at 10 25 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Mar 31, 1930

UNDERTAKER: Edmund W. Conklin — ADDRESS: 924 E. Eager St

CAUSE OF DEATH MUST BE PLAINLY WRITTEN, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 2 1930 C. HARRISON JONES, M. D.

Spec.—1-10-21—M&T—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55602

55602

CERTIFICATE OF DEATH. + 117

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 9-17 WARD)

2-FULL NAME Ida E. Walsh.

(a) RESIDENCE NO. Hamilton Ave; Rosedale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas J Walsh.

6 DATE OF BIRTH (month, day, and year): Jan 18 1867

7 AGE: Years 63 Months 2 Days 10 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS
10 NAME OF FATHER: Daniel Kimball
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.
12 MAIDEN NAME OF MOTHER: Laura Chambers.
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna.

14 Informant (Address): Thomas Walsh. Rosedale.

15 Filed MAR 30 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-28 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-20 .19 30. to 3-28 .19 30.
that I last saw her alive on 3-28 .19 30.
and that death occurred, on the date stated above, at 3 55 p m.

The CAUSE OF DEATH* was as follows:
Ruptured gangrenous appendicitis
(duration) yrs. mos 6 ds.
CONTRIBUTORY (Secondary) Peritonitis
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at home
Did an operation precede death? No Date of 3-23-30
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) W B Shedden, M. D.
19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Mar 31 1930

UNDERTAKER: Margaret E. Flynn — ADDRESS: 1432 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 55603

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland ST. 4-26 WARD)

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Henry Weinberger

(a) RESIDENCE NO. 724 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie Weinberger

6 DATE OF BIRTH (month, day, and year): Nov 13-1887

7 AGE: Years 42 | Months 4 | Days — | If LESS than 1 day, hrs. or min. 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York City

PARENTS

10 NAME OF FATHER: Moses Weinberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary

12 MAIDEN NAME OF MOTHER: Sallie Degen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Jack Lewis Jr

(Address) 1439 Eutaw St

Filed MAR 31 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/28 1930

17 I HEREBY CERTIFY, That I attended deceased (from 3/22, 1930, to 3/28, 1930,

that I last saw h/M alive on 3/28, 1930,

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Emphysema. (Chronic)

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes. What test confirmed diagnosis? Phys. Exam.

(Signed) S. F. Silver, M. D.

3/28 1930 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 3/30 1930

UNDERTAKER: Jack Lewis

ADDRESS: 1439 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55604 ✓ E 55604

E 55604

CERTIFICATE OF DEATH

185

1-PLACE OF DEATH Enroute to Johns Hopkins Hospital

City of Baltimore: (No.) St. 7-10 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman L. Rey

(a) RESIDENCE NO. 2414 Jefferson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane E. Rey

6 DATE OF BIRTH (month, day, and year) May 7/1854

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town)

(State or country) Petersburg, Va.

PARENTS

10 NAME OF FATHER ------- Rey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Jane E. Rey

(Address) 2414 Jefferson St

15 Filed MAR 30 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull, ribs & clavicle Accidentally fell to side walk at 116 N. Milton Ave when rope broke. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 116 N. Milton A

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3/29-30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem.

DATE OF BURIAL Mar. 31 1930

20 UNDERTAKER Wm. C. Miller & Son

ADDRESS 3034 Jefferson St

Cut should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 55605

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55605

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. ..... ST., 2744 WARD .....

2-FULL NAME Antoinette Jones

(a) RESIDENCE NO. 2920 Pinkwood Ave ST., ... WARD .....
(Usual place of abode) (Hamilton)
Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Clinton M. Jones.

6 DATE OF BIRTH (month, day, and year) June 12 - 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	9.	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Ernest Monfalcon

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Virginia L. Hart

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Clinton M. Jones
(Address) 2920 Pinwood.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-30

17 I HEREBY CERTIFY, That I attended deceased from 2-10, 1930, to 3-29, 1930, that I last saw her alive on 3-29, 1930, and that death occurred, on the date stated above, at 9 23 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma breast

(duration) ..... yrs. 7 mos ..... ds.

CONTRIBUTORY (Secondary) Generalized metastasis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? N Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) J. Leyko, M. D.

3/29 1930 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	4/1 1930
20 UNDERTAKER L. F. McCully	ADDRESS 130 E Fort.

TION is very important. See instructions on back of certificate.

R 1930 C. PERSON JONES, M.

Spec.—2-29-28—L. P. S.—500 Blks.

E 55606

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 55606

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 William St. ST., 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Aydelotte E. Franklin

(a) RESIDENCE NO. 1412 William St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert F. Franklin

6 DATE OF BIRTH (month, day, and year) Apr. 18 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland Md. (State or country)

PARENTS

10 NAME OF FATHER William A. Melvin

11 BIRTHPLACE OF FATHER (city or town) Pocomoke City (State or country)

12 MAIDEN NAME OF MOTHER Minnie Peregoy

13 BIRTHPLACE OF MOTHER (city or town) Talbott Co (State or country)

14 Informant Mrs. Melvin

(Address) 1412 William St

15 [illegible] C. HAMPSON JONES

MAR 30 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 20, 1930 to Mar 29, 1930

that I last saw her alive on Mar 27, 1930

and that death occurred, on the date stated above, at 12:30 p. m..

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

with Cardiac Complications

(duration) yrs. mos. 5 da.

CONTRIBUTORY (Secondary) 1 Bronchitis

(duration) yrs. mos. 10 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. E. Franklin M. D.

3/30, 1930 (Address) 1412 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Ceme

DATE OF BURIAL 3/31, 1930

20 UNDERTAKER I. Few Mc Cully

ADDRESS 130 E. Fort

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55607

HEALTH DEPARTMENT—CITY OF BALTIMORE

164

E 55607

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 223 N. Gilmore St., 19-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Slattery (SLATTERY)

(a) RESIDENCE NO. 223 N Gilmore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 15. 1830

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	99	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N.Y.
(State or country)

PARENTS

10 NAME OF FATHER John Slattery

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. Louise B. Wolf Steiner
(Address) 223 N Gilmore

15 Filed ..., 19.. C. HAMPSON JONES, M. D.
Registrar

MAR 30 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:
Old age and general debility.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brook M. D.

3/30. 1930 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	March 31 1930
20 UNDERTAKER George J. Smith	ADDRESS 1532 Holliday St.

Now among the certificates supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 55608 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55608

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3020 Darby St. ST.: 13-51 WARD)

2-FULL NAME Sarah A. McCann.

(a) RESIDENCE. No. 3020 Darby St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 50 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James McCann

6 DATE OF BIRTH (month, day, and year) Feb 9, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Gorsch (Address) 3020 Darby St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 20 1929 to Mch 29 1930.

that I last saw her alive on Mch 27 1930.

and that death occurred, on the date stated above, at 7:45a m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Hard.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

Chronic Nephritis yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. A. Richards M. D.

Mch. 29 1930 (Address) 1127 N. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Mar 31, 1930
20 UNDERTAKER Edmonds Son	ADDRESS 2110 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 3 0 1930

Spec.—2-29-28—L. F. S.—500 Blks.

E 55609 HEALTH DEPARTMENT—CITY OF BALTIMORE 51 ✓ E 55609

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland Gen Hosp WARD) B-57

2—FULL NAME Robert Emmett Ford

(a) RESIDENCE NO. 1517 W-36th ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 1y yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hilda Ford

6 DATE OF BIRTH (month, day, and year) Oct. 31-1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gas attendant

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Service Station

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Harry Ford

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Chilcott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Hosp. Records (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-30

17 I HEREBY CERTIFY, That I attended deceased from 2-6-30, 19..., to 3-29-30, 19..., that I last saw h. alive on 3-29-30, 19..., and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Congestive Heart Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Rheumatic Fever

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. K. Vans M. D.

19 (Address) Md Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	April 1 19 30
20 UNDERTAKER Thanhouser Son	ADDRESS 2110 Eutaw

Important. See instructions on back of certificates.

C. H. THOMPSON JONES M. D.

Spec.—1-10-21—M&T—1500 Blks.

E 55610 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55610

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Harryman

(a) RESIDENCE NO. 335 E. 22nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 8 - 2 - 1880

7 AGE: Years 49 Months 7 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William H Harryman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Laura Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Miss Mary Harryman

(Address) 330 E 22nd St

15 Filed MAR 30 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3 - 28 1930

17

I HEREBY CERTIFY, That I attended deceased from 3-20, 1930, to 3-28, 1930,

that I last saw her alive on 3-28-30, 19,

and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) W. W. Chenbrief, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lowdon Park Cemetery

DATE OF BURIAL: March 31 1930

20 UNDERTAKER: Mary W. Wiedefeld

ADDRESS: 50 E 22nd St

Spec.—8-16-29—L. F. S.—100 Bks.

E 55611

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55611

CERTIFICATE OF DEATH

47

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nannie Cockey Brosius

(a) RESIDENCE NO. Church Home & Infirmary ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Brosius

6 DATE OF BIRTH (month, day, and year) May-15-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cabana

(State or country) Frederick Co Md.

PARENTS

10 NAME OF FATHER Sebastian G. Cockey

11 BIRTHPLACE OF FATHER (city or town) Frederick Co

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Sprigg

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co

(State or country) Maryland.

14 Informant S. Graff Havenstick

(Address) Irberg Md.

15 Filed 19 Registrar

[illegible] C. HAMPSON JONES, M. D.

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29/30

17

I HEREBY CERTIFY, That I attended deceased from July 1 1927 to March 29 1930

that I last saw her alive on March 29 1930

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases to Lungs Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? amputation of Breast

Did an operation precede death? Yes Date of November 1928

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Vernon H. Norwood, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
FREDERICK. MD.	March 31 30
20 UNDERTAKER	ADDRESS
Hyde & Jones Inc	Pratt & Broadway

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

23 E 45 5612

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55612

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur D. Hoffman

(a) RESIDENCE NO. 227 Walnut St ST. WARD Grafton-W-Va

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos 10 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 30

(c) Name of employer

9 BIRTHPLACE (city or town) W-Va

(State or country)

PARENTS

10 NAME OF FATHER John Hoffman

11 BIRTHPLACE OF FATHER (city or town) W-Va

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) W-Va

(State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAR 30 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar-30-30

17 I HEREBY CERTIFY, That I attended deceased from Mar-22, 1930, to Mar 30, 1930, that I last saw him alive on Mar 30, 1930, and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Primary Adenocarcinoma - Left Ovary Metastasis

(duration) yrs. mos. 8 da.

CONTRIBUTORY (Secondary) Post Operative Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-27-30

Was there an autopsy? Yes

What test confirmed diagnosis? Exploration

(Signed) Howard Kelly, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grafton W Va — DATE OF BURIAL 3/30/30

20 UNDERTAKER George A Farley — ADDRESS Fuellton Fayette

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55613

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55613

CERTIFICATE OF DEATH

101-00

1-PLACE OF DEATH

City of Baltimore: (No. 1840 McCulloh St., 14-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Banks

(a) RESIDENCE NO. 1840 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day and year): June 14—1910

7 AGE: Years 19 | Months 9 | Days 16 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER: Geo Banks

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Emaline Lang

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Geo Banks
(Address): 1840 McCulloh

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Mar 30th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Feldman, M. D.

Mar 30 1930 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen, Md — DATE OF BURIAL: Apr 1 1930

20 UNDERTAKER: H. J. Tuckey Jones — ADDRESS: Md.

Use black ink and write carefully. Copies. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55614

E 55614

CERTIFICATE OF DEATH

185 20-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2119 Christian St. (Ward)

2-FULL NAME Michail J Stuart

(a) RESIDENCE NO. 2119 Christian St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Wh	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Loretta Stuart

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 56	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron Moulder
(b) General nature of industry, business, or establishment in which employed (or employer) Out
(c) Name of employer Balto

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant W. L. Hyde
(Address) 2119 Christian St

15 Filed C. HAMILTON JOHNS, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Result of accident Fell down Step Fracturing Sternal ribs Lungs Punctured & Pneumonia Hypostatic

Acute Myocarditis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (over)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Inquest

What test confirmed diagnosis?

(Signed) Chas O'Brooke, M. D.

3/30. 1930 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/31/1930
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

All statements are required by law and must be answered to the best of the knowledge, information and belief of the informant. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55615

E 55615

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH

City of Baltimore: (No. Lady Hospital St. 3-4 Ward)

2 FULL NAME Irene Hepler

(a) RESIDENCE NO. 252 S. Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1897

7 AGE: Years 33; Months —; Days —; IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): N. C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): N. C.

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): N C.

14 Informant: Flora Slater
(Address): 515 N Calhoun St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Epilepsy (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Epilepsy (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. C. Bates, M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 3-31 1926

20 UNDERTAKER: Dan'l Conlon — ADDRESS 716 Pac ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 55616

CERTIFICATE OF DEATH

E 55616

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 702 Cider Alley St., 4-29 Ward)

2-FULL NAME Annie Mason

(a) RESIDENCE NO. 702 Cider Alley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Mason

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Annie Simms

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. A. Mason
(Address) 702 Cider Alley

15 Filed APR 3 1930 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Kelly M. D.

3/29 1930. (Address) 273 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3-31 1930
20 UNDERTAKER	ADDRESS
Daniel Easton	Balto

Not should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55612 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55617

CERTIFICATE OF DEATH. 31

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 W Franklin ST. 19-27 WARD)

2-FULL NAME George H Woodlan

(a) RESIDENCE NO. 1425 W Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	c	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Operator
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

PARENTS

9 BIRTHPLACE (City or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Geo H Woodlan

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Conner

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Md.

14 Informant Leo H. Woodlan Son
(Address) 1425 W Lanvale St

15 Filed APR 1 1930 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1930, to Mar 28, 1930, that I last saw him alive on Mar 28, 1930, and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ?
(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Eugene F. Yeager, M. D.

3/31, 1930 (Address) The Gylmander

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 3-31 1930

20 UNDERTAKER Edmund Easton — ADDRESS 776 Paca

IMPORTANT—See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55618

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55618

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 629 E. 29th ST. 9-46 WARD)

2-FULL NAME Audrey C Wheeler

(a) RESIDENCE NO. 629 E 29th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28th 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER John W. Wheeler

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Pauline Smith

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant John W. Wheeler
(Address) 629 E. 29th St.

15 Filed ..... 19 C. Hampson Jones, M.D.
Registrar
COMMISSIONER OF HEALTH

APR 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1930, to March 27, 1930, that I last saw her alive on March 27, 1930, and that death occurred, on the date stated above, at 1150 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Albert Schmeltzer, M. D.

3/29 1930 (Address) 2025 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Cemetery - Sunnybrook, Md.

DATE OF BURIAL 3/31 1930

20 UNDERTAKER E. J. Fanning Inc. 1938

ADDRESS Lafayette Ave.

FOR IMPORTANT INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55619 40 ✓ E 55619

CERTIFICATE OF DEATH

1—PLACE OF DEATH Church Home & Infirmary REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 1-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adam Bartholomay

(a) RESIDENCE NO. 31 S. Linwood St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Bartholomay

6 DATE OF BIRTH (month, day, and year) Jan 27, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer) 11 years

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Justice Bartholomay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Bloom.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lilly Bartholomay (Daughter)

(Address) 31 S. Linwood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28/30

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1930, to March 28, 1930, that I last saw him alive on March 28, 1930 and that death occurred, on the date stated above, at 10:05 P.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart Disease & mitral insufficiency and Rupture of aorta

(duration) ? yrs. 1 mos. ? ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Gross & chemistry !!

(Signed) Vernon H. Norwood, M. D.

3, 28, 1930 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL First Evangelical Cemetery

DATE OF BURIAL Mar. 31 1930

20 UNDERTAKER Henry Sander & Sons Inc.

ADDRESS Baltimore St & Bentalou

Spec.—2-29-28—L. F. S.—500 Bks.

E 55620

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55620

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 E 28 St. ST., 9-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Rockner.

(a) RESIDENCE NO. 1732 E 28 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if foreign birth? 86 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Rockner

6 DATE OF BIRTH (month, day, and year) July 25, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John H. Baum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Mary Schumann Daughter

(Address) 1732 E 28 St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1930

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1930 to March 29, 1930

that I last saw h.. alive on March 29, 1930

and that death occurred, on the date stated above, at 7 20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Hypertension

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis? Urinalysis Phy.

(Signed) Thos. Fa Stevens, M. D.

3/30, 1930 (Address) 2878 Hartford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthew's Cemetery

DATE OF BURIAL Apr. 2 1930

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS Baltimore St & Broadway.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55621

E 55621 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

REGISTERED NO. 425

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. St. ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mamie Mann

(a) RESIDENCE NO. 516 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel C Mann

6 DATE OF BIRTH (month, day, and year) Jan 1 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER W. Filmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary C Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Samuel C Mann

(Address) 516 W Fayette

15 Filed Apr 3 1930, 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 22, 1930, to March 29, 1930, that I last saw h[illegible] alive on March 29, 1930 and that death occurred, on the date stated above, at 2:20 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonitis & emphysema of antrum of Highmore, Status Fibrosis and Bronchiectasis

(duration) yrs. 1 mos. 17 da.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 28, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George D. Yeager, M. D.

Mar. 29 1930 (Address) Mercy Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn bur

DATE OF BURIAL Mar 31 1930

20 UNDERTAKER N. McKenrow

ADDRESS 2238 W North

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55622 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 55622

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital S. 6-10 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Brown

(a) RESIDENCE No. 34 N. Patterson Park WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Abraham Brown

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
47		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Hospital Record
(Address)

15 Filed MAR 31 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1930, to 3/30, 1930 that I last saw h~~er~~ alive on 3/30, 1930 and that death occurred, on the date stated above, at 10:45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

Malformation (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Enteritis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross & Lab

(Signed) Jos Greenwald Jr M. D.

, 19 (Address) City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Mt. Carmel — DATE OF BURIAL 3-31-1930

20 UNDERTAKER Jack Leiss, 1439 E. Balto — ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

E 55623 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 55623

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 116 S. Curley ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Emrick

(a) RESIDENCE NO. 116 S. Curley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth Emrick

6 DATE OF BIRTH (month, day, and year) Sept 1 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Emrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Elizabeth Emrick
(Address) 116 S. Curley St

15 Filed MAR 31 1930 C. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28/1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 24 1930, to Mch 28/1930, 19, that I last saw him alive on Mch 26/30 5-15 P. m. 19, and that death occurred, on the date stated above, at P. m.

THE CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

3/31/30 (Signed) W. S. Denny M. D.

(Address) 6??? W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Mar 31 1930

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55624

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 55624

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 N. Luzerne ave ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carolyn Nowakowski

(a) RESIDENCE NO. 202 N. Luzerne ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 3 1930

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Nowakowski

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Carolyn Klein

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Mrs. Carolyn Klein (Address) 202 N. Luzerne

15 MAR 31 1930 H. [illegible] JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/27, 1930, to 3/29, 1930, that I last saw h[illegible] alive on 3/27, 1930, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Heart failure & toxemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N D Date of

Was there an autopsy? N I

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) I Irving D Antebi M. D.

, 19 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL SS. Stanislaus

DATE OF BURIAL April 1 1930

20 UNDERTAKER J. J. Kerr 156 B.

ADDRESS Luzerne

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 55625 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 55625

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3006 Pabst — ST. 8-44 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorenz Schaenlein

(a) RESIDENCE NO. — ST. — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Schaenlein

6 DATE OF BIRTH (month, day, and year): Dec 4 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
76 77 mo.		3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bldg contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Bldg Contractor 216

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Andrew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germ.

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germ

14 Informant: Mr. Aug. Schaenlein.

(Address) 300 W Pratt Side Entrance

15 Filed MAR 31 1930. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24th 1930

17

I HEREBY CERTIFY, That I attended deceased from May 25th, 1930, to March 24th, 1930, that I last saw h[e] alive on March 24th, 1930 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J Gerwig, M. D.

March 31, 1930 (Address) 1400 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: April 1 1930

20 UNDERTAKER: Jos. J. Kerr — ADDRESS: 1564 N. Luzerne

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

Spec.—1-12-23—M&T—500 Blks.

E 55626 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55626

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1013 N Castle ST. 11th WARD)

2-FULL NAME Leonora M. McGreevy

(a) RESIDENCE NO. 1013 N Castle ST. 11th WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Sept 18-21

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min
	8	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Daniel S. McGreevy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Daniel S McGreevy

(Address) 1013 N. Castle St.

15 Filed MAR 31 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/10, 1930, to 3/28, 1930 that I last saw h.. alive on 3/28, 1930

and that death occurred, on the date stated above, at ..... m

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. ..... mos 18 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical sign

(Signed) Dan'l Miller, M. D.

3/31, 1930 (Address) 150 Alwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Bern — DATE OF BURIAL April 2 1930

20 UNDERTAKER Jos. J. Kerr — ADDRESS 156 N. Luzerne

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Kotowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 55627

E 55627

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1520 Thames ST. 34 WARD)

2—FULL NAME Andrew Kotowski

(a) RESIDENCE NO. 1520 Thames ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 15 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of Josephine Kotowski

6 DATE OF BIRTH (month, day, and year) Nov 6. 1909.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	4.	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) M. tug Boat.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Kotowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Josephine Kaczmarski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Josephine Kotowski
(Address) 1520 Thames St

15 Filed APR 1 1930, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 29 1930 to March 29 1930.

that I last saw him alive on March 29 1930

and that death occurred, on the date stated above, at 730 P.m.

The CAUSE OF DEATH* was as follows:

acute Dilitation of the Heart

(Instantaneous)

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Finger M. D.

(Address) 26 E Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL April 2 1930

20 UNDERTAKER Wendell & Lloyd.

ADDRESS 320 E Eden St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55628

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55628

90

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 S. Albemarle St. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christina Festa

(a) RESIDENCE NO. 215 S. Albemarle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if foreign birth? 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatore Festa

6 DATE OF BIRTH (month, day, and year) June 21 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64 65	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work.

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Pasquale Simmizza

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Angelina Ricitta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Salvatore Festa

(Address) 215 S. Albemarle

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1929, to March 29, 1930, that I last saw her alive on Mar 28, 1930 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Renal disease

(duration) 1 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What (est confirmed diagnosis?

(Signed) Stanley L. Kendrick M. D.

3-31. 1930 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL April 1 1930

20 UNDERTAKER Kendall & Riggs

ADDRESS Fond Edwards

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55629

E 55629

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. [illegible] Wealthmilk Rd. Ward [illegible]

2-FULL NAME Alice J Lee

(a) RESIDENCE NO. [illegible] Wealthmilk Rd Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Wht

5 Single, Married, Widowed or Divorced (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1861

7 AGE: 69 Years 68 | Months | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant [illegible]
(Address) [illegible]

15 Filed ... 19... C. HAMPSON JONES, ... Registrar

31 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

May 29 19 30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Calvary Cem.

DATE OF BURIAL: 31 May 19 30

20 UNDERTAKER: Samuel A Kennedy & Bro

ADDRESS [illegible]

Instructions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 55630 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 31 E 55630

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Druid Hill Ave (WARD) 20

2-FULL NAME Meredith W. Brown

(a) RESIDENCE NO. 1715 Druid Hill Avenue WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Carrie May Brown

6 DATE OF BIRTH (month, day, and year) March 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Daniel L. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Georgianna Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Edna F. Brown
(Address) 555 Laurens St

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

MAR 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28. 1930

17 I HEREBY CERTIFY, That I attended deceased from ~~Mar. 14~~ 19~~29~~ to March 28. 1930.
that I last saw h~~im~~ alive on 3/27/ 1930,
and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* ~~was as follows~~:

Cor. T. B.

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Nature of work Caterer (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. Lee Sa M. D.

3/28. 1930 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 4/1/ 1930

UNDERTAKER Wm. Geo. H. Holland

ADDRESS 16 W Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 55631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

76 ✓

E 55631

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Volunteers America St. Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Connolly

(a) RESIDENCE NO. 2511 Emerson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed or divorced~~ (or) WIFE of James Connolly

6 DATE OF BIRTH (month, day, and year) Sept - 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Martin Kavanaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Richard Neufelder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Regina Harris

(Address) 2511 Emerson St

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 11, 1929, to Mch 30, 1930.

that I last saw h~~e~~r alive on Mch 30, 1930, at 5-35 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Paresis

(duration) 1 yrs. 8 mos ... da.

CONTRIBUTORY (Secondary) Streptococcus Septicemia (duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Laboratory

(Signed) A. J. Conrey, M. D.

, 19 (Address) Vol. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4/2/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

235310 E 55632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 55632

1—PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 13-52 St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harold Small

(a) RESIDENCE NO. Florence Crittenden Home 32nd & Chestnut ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22-1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Joseph Brenner

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Small

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30-1930

17

I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to March 30, 1930,

that I last saw him alive on March 30, 1930

and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Primary Bronchopneumonia

(duration) yrs. mos. 7 da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J R Bickford, M. D.

3/31, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 3/31 1930

20 UNDERTAKER William Cook

ADDRESS 1177 Saratoga

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 55633 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55633

135

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Joseph Hospital

CITY OF BALTIMORE: (No. Caroline Valmer St. St.) 27-43 (WARD)

2-FULL NAME John Pavitt

(a) RESIDENCE NO. 2921 Louise Avenue St.; WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Amanda Pavitt

6 DATE OF BIRTH (month, day, and year) 5/8/1864

7 AGE Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
65	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grill Manager 186

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer H. J. Heinz Co

9 BIRTHPLACE (city or town) (State or country) Ardmora Pa

PARENTS

10 NAME OF FATHER William Pavitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Angelina Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Amanda Pavitt

(Address) 2921 Louise Ave

15 Filed MAR 1 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-18 , 1930 , to 3-30 , 1930 , that I last saw him alive on 3-30 , 1930 , and that death occurred, on the date stated above, at 5 40 P m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 3-27-30

Was there an autopsy? no

What test confirmed diagnosis? Operation & Clinical

(Signed) M. Friedrich M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West Laurel Hill Cem, West Phila. Penna

DATE OF BURIAL 4/2/ 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—2-29-2[illegible] L. F. S.—500 Bks.

E 55634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 55634

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3602 E. Pratt. ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gaetano Sessa

(a) RESIDENCE NO. 3602 E. Pratt. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 26 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria Sessa

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer

(c) Name of employer Proprietor

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Pietro Sessa

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Rosaria Castro

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Chas. Sessa

(Address) 100 N. Ellwood Ave

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 1930, to 3/29, 1930, that I last saw h[illegible] alive on 3/29/30 at 3 P. m. and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart Asc Pulm Oedema

(duration) yrs. (mos.) ds.

CONTRIBUTORY (Secondary) Cardiac Asthma (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. Sutter, M. D.

3/29. 1930 Address 331 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL April 2, 1930

20 UNDERTAKER Frank V. Pipitone

ADDRESS 2818 E Balto, St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55635

CERTIFICATE OF DEATH

24001

E 55635

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2220 Alora ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Louis Schnader

(a) RESIDENCE NO. 2220 Alora ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or WIFE of): Barbara Schnader

6 DATE OF BIRTH (month, day, and year): July 11-1865

7 AGE: Years 64 | Months 8 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boilermaker

(b) General nature of industry, business, or establishment in which employed (or employer): 079

(c) Name of employer: Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Conrad Schnader

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Barbara Schnader

(Address): 2220 Alora St

15 Filed ... 19 ... H. J. JONES, M. D. Registrar

APR 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-28-1930

17 I HEREBY CERTIFY, That I attended deceased from 3-25, 1930, to 3-28, 1930, that I last saw him alive on 3-28 1930 and that death occurred, on the date stated above, at 4 05 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Kaul, M. D.

3/24 1930 (Address) 463 N Washington St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer.

DATE OF BURIAL: April 1st 1930

20 UNDERTAKER: Leo S. Cook

ADDRESS: 1723 Patterson Ave

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55636

REGISTERED NO. 167-001 E 55636

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 N Lafayette ST., 17-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Bertha Jackson

(a) RESIDENCE NO. 710 N Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 14 1930

7 AGE	Years	Months	Days 16	If LESS than 1 day, ...hrs. or ....min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susie Bowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Frank Jackson (Address) 710 Lafayette ave

15 Filed ..... 19..... Registrar

Important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 14, 1930, to Mar 29, 1930, that I last saw her alive on Mar 29, 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth (Seven Month duration)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Non Development (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. Norbridge, M. D.

3/30, 1930 (Address) 903 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL Mar 31 1930

20 UNDERTAKER Chas. Alexander

ADDRESS [illegible]

APR 1 1930

Spec.—1-30—M. & T.—250 Bks.

E 55637

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55637

CERTIFICATE OF DEATH.

90v

REGISTERED NO. 27-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 4211 Wickford Rd WARD

2-FULL NAME Thomas Frank Tyler.

(a) RESIDENCE NO. 4211 Wickford Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena W. Foxwell.

6 DATE OF BIRTH (month, day, and year) August 10 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant - Oysters

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Lena Tyler

(Address) 4211 Wickford Rd

15 Filed ..... 19 ..... C. HARRISON ..... Registrar

MAR 31 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 30, 1929, to March 29, 1930, that I last saw h... alive on March 27, 1930, and that death occurred, on the date stated above, at 5.30 A.M.

The CAUSE OF DEATH* was as follows:

arteriosclerosis - cerebral hemorrhage

(duration) 1 year mos. ds.

CONTRIBUTORY (Secondary) senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Hyde, M. D.

3-31-1930 (Address) 1100 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL March 31 1930

20 UNDERTAKER John O. Mitchell & Sons. — ADDRESS 700 Eutaw Place

THIS is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55638

CERTIFICATE OF DEATH

182

E 55638

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating in the water at

City of Baltimore: (No. Covington St. & Key Highway St. 5-8 Ward)

2-FULL NAME Albert Thomas. (C)

(a) RESIDENCE NO. 20 N. Exeter St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 31, 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	37	11	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Marine fireman. 1
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Zachariah Thomas (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sarah--------(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Stella Fibbins. (C)
(Address) 20 N. Exeter St.

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH 1930

16 DATE OF DEATH (month, day, and year) 192 Missing March 18, Body found March 25

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Probably accidental.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Fernandt, M. D.

3/31, 1930 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cemetery	4/1/30
20 UNDERTAKER	ADDRESS
Robert W. McClain	1515 N. Eden

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55639

CERTIFICATE OF DEATH

129 E 55639

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 N East ST., 16-11 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Perry

(a) RESIDENCE NO. 513 East ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edw. Perry

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE: Years 49 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs E. Perry

(Address): 513 East St

15 Filed 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28-30

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1930, to Mar 28, 1930,

that I last saw her alive on Mar 27, 30

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cardio Renal Vascular

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

3-28 1930 (Address) 508

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem.

DATE OF BURIAL: Mch 31 1930

20 UNDERTAKER: Mrs C. S. Locke

ADDRESS: 1302 Jefferson

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55640 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ 90 E 55640

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 N. Fulton Ave ST.) 6-10 (WARD)

2-FULL NAME Clara Kornmann

(a) RESIDENCE NO. 18 N. Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of William Kornmann

6 DATE OF BIRTH (month, day, and year) June 22 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Colmar

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Jung

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Germany

14 Informant William Kornmann Jr
(Address) Hamilton

15 Filed ..... 19 ..... HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1927, to March 29 1930, that I last saw her alive on March 27, 1930, and that death occurred, on the date stated above, at 2-30 P. M.

The CAUSE OF DEATH* was as follows:

Fatty degeneration of Heart muscle

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Hardening of Arteries Bright's Disease

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A C Baer M. D.

(Address) 1707 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. — DATE OF BURIAL April 1930

20 UNDERTAKER Josiah Ryder — ADDRESS 1600 W. Lexington St.

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55641

REGISTERED NO. E 55641

1-PLACE OF DEATH

City of BALTIMORE: (No. 1334 Mount St. 15-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Lawrence

(a) RESIDENCE NO. 1324 Mount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Larry Lawrence

6 DATE OF BIRTH (month, day, and year) Oct 27/90

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
29	29	5	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Holyoke N.C.

(State or country)

PARENTS

10 NAME OF FATHER James Allen

11 BIRTHPLACE OF FATHER (City or town) Holyoke N.C.

(State or country)

12 MAIDEN NAME OF MOTHER Ellen Brooks

13 BIRTHPLACE OF MOTHER (city or town) Holyoke N.C.

(State or country)

14 Informant Larry Lawrence (Address) 1324 Mount St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28-1930

17 I HEREBY CERTIFY, That I attended deceased from 3-25-1930 to 3-28-1930, that I last saw her alive on 3-26-1930, and that death occurred, on the date stated above, at 8:21 A.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the heart 5 hr

Fatty heart 5 da

(duration) ... yrs. ... mos. 1 da.

CONTRIBUTORY (Secondary) Hypertrophy heart and acute indigestion. First complaint of dyspnea 3-24-30

(duration) indigestion one day da.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Frank L. Saunders, M. D.

2-27, 1930 (Address) 1029 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

Date of Burial 4/1 1930

20 UNDERTAKER Thomas E. Pelleon

ADDRESS Question on B

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55642

E 55642

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Washburn Ave. St., 25-15 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida L. Sprouts

(a) RESIDENCE NO. 911 Washburn Ave., St., Brooklyn Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 26 da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced HUSBAND of or) WIFE of Charles Sprouts

6 DATE OF BIRTH (month, day, and year) Dec. 21, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~73~~ 69		3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St. Clairsville Belmont Co. Ohio

PARENTS

10 NAME OF FATHER William Carmen

11 BIRTHPLACE OF FATHER (city or town) St. Clairsville (State or country) Ohio

12 MAIDEN NAME OF MOTHER ? Hatcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant G. T. Cromwell (Address) Brooklyn, Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-30

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to March 29, 1930, that I last saw her alive on March 29, 1930, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Disease

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Guy T. Cromwell M. D.

3/30, 1930 (Address) 201 Patapsco Ave. Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wheeling W. Va. DATE OF BURIAL 3-30 1930

20 UNDERTAKER E & B Starke ADDRESS 115 West St.

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A 3—200 Bks.

E 55643

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 55643

CERTIFICATE OF DEATH

1-PLACE OF DEATH 312 E

REGISTERED NO.

City of BALTIMORE: (No. 312 Lorraine St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Fred Crew John Frederick Crew

(a) RESIDENCE NO. 312 E. Lorraine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine N. Crew

6 DATE OF BIRTH (month, day, and year): 4 July 24. 1851

7 AGE: Years 78 Months 8 Days 4 IF LESS than 1 day hrs. or min. 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Chas Crew

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Harford Co

12 MAIDEN NAME OF MOTHER Sophia Brenninger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Norman Crew

(Address) 312 Lorraine

15 Filed MAR 31 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1930

March 29

17 I HEREBY CERTIFY, That I attended deceased from March 14 1930 to March 29 1930

that I last saw h alive on March 29 1930

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemmorhage

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopay?

What test confirmed diagnosis? Clinical Signs

(Signed) Jas L. Hoover M. D.

3-29 1930 (Address) 842 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 PLACE OF BURIAL, CREMATION OR REMOVAL: Dublin Harford Co

Date of Burial: Mar 31 1930

20 UNDERTAKER: H. J. Eichwald Sons

ADDRESS: Hamden

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55644

CERTIFICATE OF DEATH

74-001 ✓ E 55644

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 811 Wilbert ave. WARD) Wilson Park

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Hudson Bevans.

(a) RESIDENCE NO. 811 wilbert ave. WARD Wilson Park

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Bevans

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE: Years 52; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ch Home

(b) General nature of Industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Demond Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Annie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Charles Bevans

(Address): 811 Wilbert ave

15 Filed 1930 C. HAWKINS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-29-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929, to March 29, 1930, that I last saw h alive on March 29, 1930, and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia Paralysis

(duration) yrs. 3 mos. 29 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 8 mos. 24 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles H. Horton, M. D.

March 29 1930 (Address) 7121 Bracy Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 4-1 1930

20 UNDERTAKER: John H. Scudieri — ADDRESS: 1127 Druid Hill

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55645 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55645

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 16-23 ST. (WARD)

2-FULL NAME Daniel Frazier

(a) RESIDENCE NO. 915 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of (Address) Balto. City Hosp.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-30

17 I HEREBY CERTIFY, That I attended deceased from 12-5-29, 19, to 3-30-30, 19,

that I last saw him alive on 3-30-30, 19,

and that death occurred, on the date stated above, at 1:55 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Autopsy

(Signed) Marion M. McLean, M. D.

3-31, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 3-31, 1930

20 UNDERTAKER John H. Trader — ADDRESS 1027 Lend Hill

TION is very important. See instructions on back of certificates.

M 31 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

E 55646

CERTIFICATE OF DEATH

E 55646

REGISTERED NO.

1—PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Fayette & Calvert ST. 1755 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Dora Goodman

(a) RESIDENCE NO. 5718 Maple Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White Jewish	Married

5a If (married, widowed, or divorced) HUSBAND of (or) WIFE of Ralph Goodman

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Louis Orentrouck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Hontkam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Abraham Goodman

(Address) 4131 Crumpler Ave

15 Filed APR 31 1930, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/30

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to March 30, 1930, that I last saw her alive on March 30, 1930 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia right lower lobe

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Wm. B. Schreiber, M. D.

3/30, 1930 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 4/1 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1424 E Balto St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Schoenig

55647

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-061

E 55647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Margaret Schoenig S. 26 W. 40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 3430 Belair Rd

(a) RESIDENCE NO. Same 3430 Belair Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nicholas Schoenig

6 DATE OF BIRTH (month, day, and year): June 11-1875

7 AGE: Years 54 Months 9 Days 20 If LESS than 1 day, hrs. or min. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Nicholas Hetz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Gertrude Knorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Nicholas Schoenig (Address) 3430 Belair Rd

15 Filed MAR 31 1930 HAMPSON JONES, M. D. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24 1930

17 I HEREBY CERTIFY, That I attended deceased from February 6, 1930, to March 24, 1930, that I last saw her alive on March 23, 1930 and that death occurred, on the date stated above, at 2.50 A m

The CAUSE OF DEATH* was as follows: -

Lobar Pneumonia

Acute Rheumatic Fever

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Hemiplegia, Uremia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination Urinalysis

(Signed) Allen K. Krebs, M. D.

March 31, 1930 (Address) 2025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rood April 1-30

DATE OF BURIAL 19

20 UNDERTAKER: Jos. J. Osterhaus Son

ADDRESS 156 Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55648

E 55648 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 N Washington St 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Slivecky

(a) RESIDENCE NO. 902 N Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Slivecky

6 DATE OF BIRTH (month, day, and year) May 3, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Frank Pletka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Catherine Hirt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant William Slivecky

(Address) 920 N Washington St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 30 to March 30 19 30,

that I last saw h.er alive on March 30 30;

and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows: —

Uterine Carcinoma

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) Louis Frauer, M. D.

, 19 (Address) Fed. and Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 1 1930

20 UNDERTAKER Frank Leach & Son — ADDRESS 19 Oakland

important. See instructions on back of certificates.

Spec. 100 Bks.

E 55649

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55649

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 4506 Ashalanda Ave. ST. 26-39 WARD)

2—FULL NAME Barbara Klima

(a) RESIDENCE NO. 4506 Ashland Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wenceslaus Klima

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Klima

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Austria

14 Informant Victoria Barcley

(Address) 4506 Ashland Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1930, to Mar. 28, 1930, that I last saw her alive on Mar. 28, 1930 and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Novak, M. D.

, 19 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL April 1 19 30

20 UNDERTAKER Frank Cvach & Son

ADDRESS 1906 Ashland Ave

APR 3 1930 H. ... JONES, M. D. Registrar

Face

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55650 E 55650

CERTIFICATE OF DEATH.

REGISTERED NO. 23

1-PLACE OF DEATH Sinai Hosp.

CITY OF BALTIMORE: (No. 27-55 St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie L. Nelson

(a) RESIDENCE No. 6103 Baltimore Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis B. Nelson

6 DATE OF BIRTH (month, day, and year): March 12, 1892

7 AGE: Years 38 Months — Days 18 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York N. Y.

PARENTS

10 NAME OF FATHER: Hyman Zitkin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. L. B. Nelson

(Address) 6103 Baltimore Ave

15 Filed MAR 31 1930 C. HAMILTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-30 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/11 1930 to 3/30 1930, that I last saw h[illegible] alive on 3-30 1930, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B F Cohen M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft. Lincoln Cem. Md. DATE OF BURIAL 4/1/1930

20 UNDERTAKER: Harry Sondheim ADDRESS 15-20 W. Mt. Royal Ave

TION is very important. See instructions on back of certificate. Exact statement of OCC[illegible]A-

1-30—M. & T.—100 B—50L

E 55651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1930 E 55651

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Ft of Hackard Hosp (WARD) 4

2-FULL NAME Unknown Unknown

(a) RESIDENCE NO ..... ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45?	—	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed ..... 1930 ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

Acc? Drowning

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J C Healy, M. D.
Coroner

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER: C. HAMPSON JONES, M. D. Commissioner Health

ADDRESS MAR 31 193

MAR 31 1930 ... Registrar

1-30—M. & T.—100 B—50L

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55652 | E 55652

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 7 S President ST. 3-5 WARD)

2-FULL NAME Unknown Unknown

(a) RESIDENCE NO ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
55-?		—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country)

14 Informant .....
(Address)

15 Filed ..... 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

acc. Drowning

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H C Hades, M. D.
Coroner

19 (Address) 1435 76 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS

MAR 31 1930

C. HAMPSON JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55653

CERTIFICATE OF DEATH

23-31

E 55653

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 127 W. West St. St., ... Ward)

2-FULL NAME Arthur Neely.(C)

(a) RESIDENCE NO. 127 W. West St. St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed or divorced
HUSBAND of ~~WIFE of~~ Fannie Neely.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	82	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina.
(State or country)

PARENTS

10 NAME OF FATHER Gordon Neely.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Lizzie J. Riddle.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) South Carolina.

14 Informant John Wilson.(C) cousin.
(Address) 1607 Edmondson Ave.

15 Filed MAR 1 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 14, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) and inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage due to a stab-
wound of the heart.
Homicide.

(duration) ... yrs. ... mos. 0 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquest.

(Signed) [signature] M. D.

3/29 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
PUBLIC CEMETERY	
20 UNDERTAKER Commissioner Health	ADDRESS MAR 3 1930

THE MORAN CO. Bar. Wm. F. Moran

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55654

CERTIFICATE OF DEATH

161-001 ✓ E 55654

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lola M. Sharer

(a) RESIDENCE NO. 212 N. Shuhsonn St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 15, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Marshall Sharer

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Records — (Address) JOHNS HOPKINS HOSPITAL JOHNS HOPKINS HOSPITAL

15 Filed MAR 31 1930 C. HAMPSON JONES, M. D. Registrar

Per 1197

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25-30

17 I HEREBY CERTIFY, That I attended deceased from Mar - 25 - 1930, to Mar. 25 - 1930, that I last saw her alive on Mar. 25 - 1930 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? —

(Signed) J. W. Bickford, M. D.

3/26 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS MAR 31 1930

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 55655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 55655

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 926 E North Ave Ward 14)

2-FULL NAME Mary C Kenedy

(a) RESIDENCE NO. 926 E North Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Kenedy

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years 75 yr | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Ireland

(State or country)

PARENTS

10 NAME OF FATHER: Michael McKeon

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

14 Informant: Mrs Elizabeth Kenedy

(Address): 926 E. North Ave

15 Filed ....., 19..... C. HAMPSON JONES, M. D. Registrar

APR 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from February 11th 1929, to March 28th, 1930, that I last saw h[illegible] alive on March 28th, 1930, and that death occurred, on the date stated above, at 6 10 a.m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus

(duration) 7 yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! No Date of —

Was there an autopsy! No Clinical & Lab.

What test confirmed diagnosis?

(Signed) J B Saunder, M. D.

3/31/1930 (Address) 719 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

Date of Burial: April 1 1930

20 UNDERTAKER: Mary M Medairy

ADDRESS 512 228 St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—2½ Blks

Dr Krifer Ford Road

E 55656

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55656

CERTIFICATE OF DEATH.

91

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 148 Paloma Ave ST. 20-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Meier

(a) RESIDENCE NO. 148 Paloma Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Margaret Meier

6 DATE OF BIRTH (month, day, and year) Nov 4th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Building 59

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Meier

(Address) 148 Paloma Ave

15 Filed APR 3 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to Mar 30, 1930, that I last saw h~~er~~im alive on Mar 30, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Hypertension

(duration) yrs. moe de.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. moe. 2 de.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cl & Phy Exam

(Signed) F T Kyper, M. D.

, 19 (Address) 3321 Preab Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 4/3/1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul st

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Dr Blades

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55657

CERTIFICATE OF DEATH.

57

E 55657

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 730 Oldham St. 16-31 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Cooper

(a) RESIDENCE NO. 730 Oldham St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Cooper

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE: Years 71 | Months — | Days — | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Unknown

(State or country)

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): unknown

14 Informant: Daisy Hoppel

(Address): 730 Oldham St.

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture of Skull Fall

Contributory Senility (duration) yrs. 1 mos. 2 ds.

(Signed) G C Blades M. D.

(Coroner)

31 March 1930 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery Date of Burial 4/1 1930

20 UNDERTAKER: Williams Cook ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55658

CERTIFICATE OF DEATH

90 E 55658

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2830 Westwood St. 15-68 Ward)

2-FULL NAME Wm J. Sewell.

(a) RESIDENCE NO. 2830 Westwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E

6 DATE OF BIRTH (month, day and year) July 15-1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	55	8	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) 966
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER Geo W. Sewell
11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mary E. Sewell
(Address) 2830 Westwood

15 Filed ..., 19... ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. Leek, M. D.
May 30 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 6/3/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 31 1930 C. HUDSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

E 55659 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55659

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 21-31 ST., WARD)

2-FULL NAME Chas F. Frolich

(a) RESIDENCE NO. 1012 Russell St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of or) ~~WIFE of~~ Mamie Frolich

6 DATE OF BIRTH (month, day, and year) Nov - 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
65	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer B & O

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records.

(Address)

Filed APR 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31-30

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1930, to 3-31, 1930, that I last saw ~~him~~ alive on 3-31, 1930, and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical

(Signed) J Geyko M. D.

3/31, 1930 Address Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 4/3/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55660 | 129 E 55660

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4031 Bellwood ave ST. 27-43 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura V Pryor (PRYOR)

(a) RESIDENCE NO. 4031 Bellwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of George Pryor

6 DATE OF BIRTH (month, day, and year) 3-29th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Clara Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Pryor

(Address) 4031 Bellwood ave

15 Filed APR 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30th-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1930, to Mar 30, 1930, that I last saw h alive on Mar 28, 1930 and that death occurred, on the date stated above, at 1105 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) unknown (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Wm. T. Seabury, M. D.

3/31, 1930 (Address) 636 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Angel Hill Cem Haver de Grace Md.

20 UNDERTAKER J. A. Pennington + Son Haver de Grace Md.

DATE OF BURIAL 4-1st 1930

ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55661

CERTIFICATE OF DEATH

E 55661

REGISTERED NO. 71-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2530 Fait Ave ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Kalendek

(a) RESIDENCE NO. 2530 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Famale	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Kalendek

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Ksiazek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Kalendek Son

(Address) 2530 Fait Ave

15 Filed 3 1 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1930

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to March 30, 1930, that I last saw her alive on " 30, 1930 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

~~Coma~~ Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. C. Ives, M. D.

3/31/30, 19 (Address) 405 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	April 2nd 1930
20 UNDERTAKER John McNulty & Son	ADDRESS 1 N. Charles St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55662

CERTIFICATE OF DEATH

45 E 55662

1—PLACE OF DEATH

REGISTERED NO. 27-53

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry D. Hollyes

(a) RESIDENCE NO. 121 Woodlawn Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Elsie Hollyes

6 DATE OF BIRTH (month, day, and year) March 20, 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Friedrich Hollyes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Bultmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Henry Hollyes

(Address) 121 Woodlawn Rd.

15 Filed APR 3 1930, 19 C. HAMPSON JONES, M. D. Registrar

By R. C. A.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to March 30, 1930; that I last saw h alive on March 30, 1930 and that death occurred, on the date stated above, at 5.'60 A. m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal Sarcoma

Pan mon.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Metastasis Lung (R)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 121 Woodlawn Rd.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) A. R. Wilkerson, M. D.

3/30, 1930 (Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Apr. 1 1930
20 UNDERTAKER Joseph S. Cook	ADDRESS 1003 West Baltimore St.

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55663

CERTIFICATE OF DEATH.

E 55663

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2675 Maryland Ave Ward 5)

2-FULL NAME Margaret E. Gavin (GAVIN)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2675 Maryland Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. C. Gavin

6 DATE OF BIRTH (month, day, and year): 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: Daniel Shanahan

11 BIRTHPLACE OF FATHER (city or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Carr

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country)

14 Informant: Wm. C. Gavin

(Address): 2675 Maryland Ave

15 Filed MAR 31 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 30th, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1930, to March 30, 1930,

that I last saw h.. alive on March 30, 1930,

and that death occurred, on the date stated above, at 10 20 a.m.

The CAUSE OF DEATH* was as follows: Diabetes Duration four years

History given by patient and

to myasthenia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Diabetic coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Exam. autopsy.

What test confirmed diagnosis?

(Signed) Chas R Davis M. D.

, 19 (Address) 1108 Brookfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

Date of Burial: 4/1 1930

20 UNDERTAKER: J. F. Shaughnessy

ADDRESS: 318 Eight

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55664 ✓ 161-001 E 55664

E 55664

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 515 Oxford St. 17-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby boy Welsey

(a) Residence No. 515 Oxford St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 3/30/30

7-AGE. ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 2 hrs. or 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General natnre of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country).

PARENTS.

10-NAME OF FATHER, Joseph Welsey

11-BIRTHPLACE OF FATHER (city or town) Balto Md. (State or Country).

12-MAIDEN NAME OF MOTHER, Alice Groome

13-BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or Country).

14- (Informant) Joseph Welsey Pt

(Address) 515 Oxford St

15- Filed ..... 193... C. HARRY JONES, M. D. Registrar.

By .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 3/30/30

17- I HEREBY CERTIFY, That I attended deceased from March 30 1930 to Mar 30 1930,

that I last saw h[illegible] alive on Mar 30 1930,

and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Pre-maturity (30 Wks).

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Maternal Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Lemmon Jr. M. D.

3/31, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn

DATE OF BURIAL. Apr 1 1930

20-UNDERTAKER, John H. Toadvine

ADDRESS 1027 Hanover

APR 1 1930

Per 1004

In plain terms, so that it may be properly classified. Each statement of information is very important. instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55665

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

REGISTERED NO. E 55665

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1073 W Lafayette ST., 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Hall

(a) RESIDENCE NO. 1073 W Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hall

6 DATE OF BIRTH (month, day, and year) March 10 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lawson Plumer

11 BIRTHPLACE OF FATHER (city or town) Howard (State or country) Co Maryland

12 MAIDEN NAME OF MOTHER Eliza Ludwick

13 BIRTHPLACE OF MOTHER (city or town) Howard (State or country) Co Maryland

14 Informant James A Hall

(Address) 1073 W Lafayette St

Filed APR 1 - 1930 C. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1930

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1930, to March 28, 1930, that I last saw h[illegible] alive on March 28, 1930 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. 21 mos. 21 ds.

CONTRIBUTORY (Secondary) Ca Pharynx

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) A K Glover M. D.

(Address) 1073 S. Broadway Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn April 1st 1930

DATE OF BURIAL

20 UNDERTAKER Joseph A Lively

ADDRESS 409 N Monroe St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Mary C. Albert

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55666

E 55666

CERTIFICATE OF DEATH

1—PLACE OF DEATH Hospital of the Sisters of Maryland REGISTERED NO. 13-167

CITY OF BALTIMORE: (No. Lafayette and Linden ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary Catherine Albert

(a) RESIDENCE NO. 3403 Lyndenter Road. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Albert

6 DATE OF BIRTH (month, day, and year) November 22, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	4	8	

8 OCCUPATION OF DECEASED None 037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Maryland (State or country)

PARENTS

10 NAME OF FATHER Clemens Fuhrmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Buechler

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Virginia

14 Informant Bertha Fuhrmann Teagarden

(Address) 3403 Lyndenter Road

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to March 30, 1930, that I last saw h.r alive on March 30, 1930 and that death occurred, on the date stated above, at 7:34 P. m.

The CAUSE OF DEATH* was as follows:

General septicaemia due to oral sepsis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Theo G. Woodyer, M. D.

, 19 (Address) Womans Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	April 2, 1930
20 UNDERTAKER Chas. E. Franck	ADDRESS 502 Madison Ave

Important. See instructions on back of certificates.

APR 1 1930 HAMILTON JENKINS, M. D.

Cor.—10-10-29—A Co.—100 Bks.

E 55667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

21 E 55667

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1337 N. Stricker St.) 15-22 Ward)

2-FULL NAME Pattie Mickney.

(a) RESIDENCE NO. 1337 N. Stricker St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmle | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robt Mickney

6 DATE OF BIRTH (month, day, and year): 1905

7 AGE: Years 25 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER Sam. Windle.

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Ophelia

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Robt Mickney
(Address) 1370 Whitelock

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) J. Bowie Duke, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn | DATE OF BURIAL: April 1 1930

20 UNDERTAKER: Virginia Brooks 146 | ADDRESS: 3 N Carey

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 1 - 1930 C. HAMPTON JONES M.D.

Spec.—8-16-29—L. F. S.—100 Bks.

-307
32-55668

HEALTH DEPARTMENT—CITY OF BALTIMORE

A 55668

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. 1623 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence Stackhouse

(a) RESIDENCE NO. 426 Hanlem ST., Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10 -1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Lawrence Stackhouse

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Priscilla Satchell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Parent
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30-30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 24, 1930, to Mar. 30, 1930, that I last saw him alive on Mar. 30, 1930 and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pericarditis - fibropurulent - pneumonia
Lobar pneumonia bilateral
Empyema bilateral

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. W. Bickford, M. D.

3/31, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL April 1 19 30

20 UNDERTAKER Samuel F. Hemsley

ADDRESS 1718 N Bdle

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55669

CERTIFICATE OF DEATH.

2 E 55669

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. 22-31 ST. (WARD)

2-FULL NAME Robert Jones

(a) RESIDENCE NO. 835 S. Warner st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Jones

6 DATE OF BIRTH (month, day, and year) Jan. 10, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas H. Jones

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia ?

12 MAIDEN NAME OF MOTHER Josephine Buick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed [illegible] 1930 C. HAMILTON JOHNS, M. D.

By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to March 28, 1930, that I last saw him alive on March 28, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas Gilmore, M.D.

3-28-30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem

DATE OF BURIAL 4/1 1930

20 UNDERTAKER Samuel Hensley

ADDRESS Baltimore

ATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

55670

REGISTERED NO. E 55670

1-PLACE OF DEATH

City of BALTIMORE: (No. 3030 Baker St. 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma A Haines

(a) RESIDENCE NO. 3030 Baker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 81

7 AGE	Years	Months	Days
	79	1	13

IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 069

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Ephriam Haines

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Cassell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Laurel R Haines

(Address) 3030 Baker St

APR 1 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1930, to Mar 30, 1930, that I last saw h alive on March 29, 1930, and that death occurred, on the date stated above, at ____ m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Nephritis (Chronic)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clara Jones, M. D.

March 31, 1930 (Address) 706 Hoffman Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Md.

Date of Burial April 2 1930

20 UNDERTAKER W M Coulson

ADDRESS 2238 N Mon

HAMILTON JONES, M. D.

Dat

Use blood or carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55671

CERTIFICATE OF DEATH

90 ✓ E 55671

REGISTERED NO. 2863

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4216 Hayward Ave.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Milton St. Clair Disney

(a) RESIDENCE NO. 4216 Hayward Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 6 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of: Mary E. Disney

6 DATE OF BIRTH (month, day, and year): Sept. 20, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Supervison

(b) General nature of industry, business, or establishment in which employed (or employer): Building 086

(c) Name of employer: Inspectors Office

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Israel H Disney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Sarah A Corbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Md

14 Informant: Mrs Mary E Disney

(Address) 4216 Hayward Ave

15 Filed 1930 19 C. HAMPSON JONES, M. D. Registrar

R 1

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 29-30

17 I HEREBY CERTIFY, That I attended deceased from April-2, 19 28, to March 29, 19 30, that I last saw h alive on March 29-, 19 00 and that death occurred, on the date stated above, at 11 20 p. m.

The CAUSE OF DEATH* was as follows:

General Arterio-Sclerosis (Cardio-Vascular Dis)

(duration) 2 yrs. — mos. — da.

CONTRIBUTORY (Secondary): Coma — Toxemia

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Frank E Bruce, M. D.

19 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: APR 2 1930

20 UNDERTAKER: Geo W Little

ADDRESS 2708 EDMONDSON AVE.

Important. See instructions on back of certificates.

E 55672

STATE OF MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH E 55672

County

Registration Dist. No.

Village or City Baltimore (No.) 4318 Falls Rd St. 27-57 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Howard W. Ecker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Mar (Month) 30 (Day) 1882 (Year)

7 AGE: 48 yrs. — mos. 2 ds. If LESS than 1 day hrs. or min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Labourer
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: David W. Ecker

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lizzy West

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lizzy Ecker

(Address) Pikesville, Md.

15 Filed 1932 C. HAMPSON JONES, M. D. Registrar

If more blanks are needed, apply to State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

1 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 1 (Day) 1930 (Year)

17 I HEREBY CERTIFY, That I attended the deceased from Feb 1 1930 to April 1 1930, that I last saw h alive on March 31 1930, and that death occurred on the date stated above, at 2 4 m.

The CAUSE OF DEATH * was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

Contributory Secondary

(Duration) yrs. mos. ds.

(Signed) C. F. Crumbaker M. D.

4/1 1930 (Address) 3101 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Bethel

DATE OF BURIAL: April 3. 1930.

20 UNDERTAKER: J. H. Skinner

ADDRESS: Pikesville Md

Cor.—10-10-29—A Co.—100 Bks.

E 55673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55673
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH St Agnes Hosp

City of Baltimore: (No. 75-77 St., Ward)

2-FULL NAME Frank E Young

(a) RESIDENCE NO. Laurel Md St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 Sex M | 4 Color or Race Wh | 5 Single, Married, Widowed or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Young

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) Washington
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs Mira Young
(Address) Laurel Md

15 Filed ..... 19 ..... C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck down by moving auto while walking along Wash road at Savage Md
Hrs. (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wash Rd at Savage

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. H. Mann, M. D.

3-31, 1930 (Address) Savage Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Savage Md — DATE OF BURIAL 4-2 1930

20 UNDERTAKER Lloyd Kaiser — ADDRESS Laurel Md

APR 1 1930

Fill should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

234334

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55674

E 55674

CERTIFICATE OF DEATH

REGISTERED NO. 16-39

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Crawford

(a) RESIDENCE NO. 3515 E. Fairmount ST., Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24-30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Clarence Crawford

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Marie McCaufield

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 1 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 31-30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 25, 1930, to Mar. 31, 1930, that I last saw him alive on Mar. 31, 1930, and that death occurred, on the date stated above, at 6 50 a-m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? none

(Signed) J. W. Bickford, M. D.

3/31, 1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL April 1st 1930

20 UNDERTAKER Frank V. Pekitone

ADDRESS 2918 E. Balto st

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55675

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55675

CERTIFICATE OF DEATH.

REGISTERED NO. 15-65 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2914 London Ave. (WARD) 15-65

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Pauline Mueller

(a) RESIDENCE NO. 2914 London Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. C. Mueller

6 DATE OF BIRTH (month, day, and year) March 14 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Leesburg (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. Fredrick Bender

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Fricker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant J. Roy Mueller (Address) 3402 Powhatan Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29. 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/11, 1930, to 3/29, 1930, that I last saw him alive on 3/29, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. A. Schaupeck, M. D.

3/31 1930 (Address) 206 Fairview

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL April 1930

20 UNDERTAKER Wm. J. Fickner Son ADDRESS N. Y. Ave.

HARRISON JONES, M.

TION is very important See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 55676

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 55676

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No.) 2038 Robb ST., 9-18 (WARD)

2-FULL NAME Sadie Alpmira Lewis

(a) RESIDENCE NO. 2038 Robb St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 34 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Lewis Sr.

6 DATE OF BIRTH (month, day, and year) May 10, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Md

PARENTS
10 NAME OF FATHER Wm C. Cahoon
11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md
12 MAIDEN NAME OF MOTHER Annie M. Bull
13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant Charles L. Lewis Jr.
(Address) 1007 Darley Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 29 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1930, to Mar 29, 1930, that I last saw her alive on Mar. 29, 1930, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows: Myocardial dneuff.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) Arthur C Manning M. D.
3/31, 1930 (Address) 800 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL Apr 1 1930

20 UNDERTAKER Wm J Pickner & Son ADDRESS North Ave

TION is very important. See instructions on back of certificates.

Spec.—2-19-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55672

CERTIFICATE OF DEATH

5 1 E 55672

1—PLACE OF DEATH Woman's Hospital

REGISTERED NO. 13-59

CITY OF BALTIMORE: (No. ... ST. ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Barclay Aptell

(a) RESIDENCE NO. 2128 Callow Ave. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March-3-1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
13	-	✓	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work student

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Vernon Aptell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER May Barclay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant mother (May Barclay)

(Address) 2128 Callow Ave. Aptell

15 Filed APR 1 - 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March-31-1930

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to March 31, 1930, that I last saw her alive on March 31, 1930 and that death occurred, on the date stated above, at 2 25 P. m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic endo-cardilis

(duration) - yrs. 3 mos. - ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) - yrs. - mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Dale P. Clemson, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Apl. 2, 30
20 UNDERTAKER Wm Fickus Sons	ADDRESS North Pa

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55678 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55678

CERTIFICATE OF DEATH.

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2312 Bryant ave ST.) (WARD)

2-FULL NAME Mrs. Rose Levin

(a) RESIDENCE NO. 2312 Bryant Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Levin

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE: Years 56 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Richmond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bell. Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Louis Levin (Address) 2312 Bryant Ave

15 Filed ____ 19__ C. THOMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1, 1930.

17 I HEREBY CERTIFY, That I attended deceased from February, 1929, to March, 1930, that I last saw h. alive on March 31, 1930, and that death occurred, on the date stated above, at 6.40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right Kidney

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Metastasis to lungs

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 5, 1929.

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

Signed H. Edmund Levin, M. D.

4/1, 1930 (Address) 3037 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel

DATE OF BURIAL: 4/1 1930

20 UNDERTAKER: Jack Levin

ADDRESS: 1409 E Baltimore St

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55679

CERTIFICATE OF DEATH

REGISTERED NO. 203 55679

1-PLACE OF DEATH
City of Baltimore: (No. G St Jos Hosp. St., 8-17 Ward)

2-FULL NAME Phillip Byrd

(a) RESIDENCE NO. 1324 N Bdwy St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of Louise J Byrd

6 DATE OF BIRTH (month, day, and year) Jan 9 1901

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29	2	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer ~~Harry Byrd~~

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Harry Byrd

11 BIRTHPLACE OF FATHER (city or town) Not known
(State or country)

12 MAIDEN NAME OF MOTHER Magdelen Hoffman

13 BIRTHPLACE OF MOTHER (city or town) Not known
(State or country)

14 Informant Mrs. Louise J. Byrd
(Address) 1324 N. Broadway

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death of the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knock down by moving auto while walking along road

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Fullerton Md

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) G. J. Hamm M. D.

4/1, 1930 (Address) 2939 Mi Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Apr. 2 1930

20 UNDERTAKER Henry Hoen Sons Inc — ADDRESS 1301 E Eager St

C. HAMILTON JOHNS, M. D. Registrar

1 1930

Cause should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55680

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55680

CERTIFICATE OF DEATH

REGISTERED NO. 24-33

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1002 William ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Jane Gronewell

(a) RESIDENCE NO. 1002 William ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 9 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Gronewell

6 DATE OF BIRTH (month, day, and year) June 7 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Coyle

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New York

12 MAIDEN NAME OF MOTHER Jane Harrison

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Philadelphia, Pa.

14 Informant Alice E. Gronewell

(Address) 1002 William St.

15 Filed [illegible] 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 23 1930 to Mar 31 1930

that I last saw h[illegible] alive on Mar 31 1930

and that death occurred, on the date stated above, at 11.30 P. M.

The CAUSE OF DEATH* was as follows:

Right Side hemaplegia

mos 2 3 (duration) Sub Mrs. 31 mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) W Wallace Walker, M. D.

. 19 (Address) 910 Light Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

DATE OF BURIAL April 3 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 001 E 55681

1—PLACE OF DEATH

REGISTERED NO. 27-33

CITY OF BALTIMORE: (No. 12 E. Montgomery ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harden S. Markland

(a) RESIDENCE NO. 12 E Montgomery ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 6 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Markland

6 DATE OF BIRTH (month, day, and year) September 6 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employee do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Moses Kahn

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER James H Markland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Emma Markland

(Address) 12 E. Montgomery St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1930

17 I HEREBY CERTIFY, That I attended deceased from 3.25.30, 19..., to 3.30.30., 19..., that I last saw h[illegible] alive on 3.30.30., 19... and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) - yrs. - mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) Philip B. Fawlen, M. D.

3.31.30. (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 2 1930
20 UNDERTAKER John H. Denny	ADDRESS 115 Light St

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55682 | 11 | E 55682

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST., 27-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence L. Rhodes

(a) RESIDENCE NO. 5205 Catalpha Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Rhodes

6 DATE OF BIRTH (month, day, and year) June 4 [illegible] 73

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Gambrill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Valentine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John L. Rhodes (Address) 5205 Catalpha Road

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-30

17 I HEREBY CERTIFY, That I attended deceased from 1-20, 1930, to 3-29, 1930, that I last saw h[illegible] alive on 3-29, 1930 and that death occurred, on the date stated above, at 11.45a m.

The CAUSE OF DEATH* was as follows:

Appendicual Abscess — Intestinal Obstruction — General Peritonitis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes - Date of 3-13-30 3-22-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M.C. Porter fried, M. D.

3/29, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL April / 1930

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55683

CERTIFICATE OF DEATH.

57 ✓ E 55683

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) St. Agnes Hospital (St.) 70-69 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Evelyn Schaffler

(a) RESIDENCE NO. 2529 W. Pratt St. (St.) ..... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of nnn

6 DATE OF BIRTH (month, day, and year) Aug 30 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employee

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer Smith's Box Factory

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. Schaffler

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary L. Fagan

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Geo Schaffler
(Address) 2529 W. Pratt St

15 Filed ....., 19.. er ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-25, 1930, to 3/30, 1930, that I last saw her alive on 3/30, 1930, and that death occurred, on the date stated above, at 8 25 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus, Diabetic Coma

(duration) ..... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Otitis media complicating a cold (duration) ..... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

3/30, 1930 (Signed) Dr Paul Cohen, M. D.

(Address) St Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL April 2 1930

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 E 55684

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 55684

1-PLACE OF DEATH (near Ct Donnell &)

City of Baltimore: (No. Trappe Road- St., 1-3 Ward)

2-FULL NAME Frank Lukiewicz Lukas

(a) RESIDENCE NO. 216 Eastern Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustie

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Kajer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Anna Lukiewicz
(Address) 216 Eastern Ave

15 Filed ..... 19..... JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Gun Shot wound of Chest, Instantaneous
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Shy & Shadel

(Signed) ..... M. D.

19 ..... (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	April 3 1930
20 UNDERTAKER H. W. Ozazewski	ADDRESS 1930 Eastern Ave

Must should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 1 - 1930 C. HAMILTON JONES, M. D.

Filed

Spec.—1-36—M. & T.—250 Blks.

E 55685 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 55685

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST 1359 WARD

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beulah Thomas

(a) RESIDENCE NO. 2316 Division st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Will Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lillian ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed MAR 31 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 28, 19 30, to March 28, 19 30, that I last saw her alive on March 28, 19 30, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical

(Signed) Jas Gilmore M.D.

3-29 19 30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 4/1 1930

20 UNDERTAKER Thomas & Nelson

ADDRESS 1308 Preston St

ATTENTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55686

CERTIFICATE OF DEATH.

11-15 / 111-001 E 55686

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Guilford Ave. ST., WARD)

2-FULL NAME Joseph E. Brown

(a) RESIDENCE NO. 1200 Guilford Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 15th. 1883

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt.

(b) General nature of industry, business, or establishment in which employed (or employer) Beef Business

(c) Name of employer Kingan's Beef Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Patrick Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary McCormick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto,

14 Informant Miss Catherine Brown.

(Address) 2507 N. Charles St.

15 Filed 1930. C. HARRISON JONES, M. Registrar. By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31st. 30

17 I HEREBY CERTIFY, That I attended deceased from 3/20/30, 19 , to 3/31/30, 19 .

that I last saw him alive on 3/30/30, 19 .

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis —
(Gastric Ulcer?)

(duration) yrs. 6. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Sargeaders, M. D.

4/1/30 19 (Address) 321 E 25—

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL April 2. 1930

UNDERTAKER Chas F. Grace & Son

ADDRESS 1180 W. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

55687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-203

E 55687

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hosp St. 16-37 Ward)

2-FULL NAME Matilda E Wetzel

(a) RESIDENCE NO. 7008 Dunbar Rd St., Dundalk Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Apr 11-29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	87		19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Died
(b) General nature of industry, business, or establishment in which employed (or employer) Hsd
(c) Name of employer Balto Co

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Chas Wetzel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary V Gabriel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Charles J Wetzel
(Address) 7008 Dunbar Road Dundalk

15 Filed [illegible] 19[illegible] [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I [illegible] the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was, as follows:
Auto fire in which she was riding overturned causing Chest Fracture
(duration) yrs. mos. ds.
DC,
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Parkton Md
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) J. H. Frame, M. D.
Apr. 1930 (Address) 4934 W Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Mt. Carmel Cemetery

DATE OF BURIAL
Apr. 2 1930

20 UNDERTAKER
George W. Zinkler

ADDRESS
1737 E. Eager St

Filed APR 1 1930 C. HAMPSON JONES, M. D. Registrar

Be sure that should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

55688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55688

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument St. 18-76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anita Zweigel

(a) RESIDENCE NO. 1207 W. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 19/29

7 AGE — Years: 0 | Months: 7 | Days: 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md

PARENTS

10 NAME OF FATHER: Morris Zweigel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Anna Hyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Morris Zweigel (Address) 1207 W. Baltimore St.

15 Filed 19 Registrar

C. HAMPSON JONES, M. D.

PR 1 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 1 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19 1930. to April 1 1930.

that I last saw her alive on April 1 1930

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicaemia

(duration) 0 yrs. 0 mos. 14 ds. (?)

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 0 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + laboratory findings

(Signed) Jacobi & Cohn M. D.

4/1 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Fem

DATE OF BURIAL: 4/1 1930

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS (12) E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 55689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-9-32 E 55689

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2104 Moyer St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Baby Boy Wroblewski

(a) RESIDENCE NO. 2104 Moyer St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 3-29-30

7 AGE Years Months Days 2 3

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balt

(State or country): Md

PARENTS

10 NAME OF FATHER: Frank Wroblewski

11 BIRTHPLACE OF FATHER (City or town): Russia

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Petronella Zymiewicz

13 BIRTHPLACE OF MOTHER (city or town): Warsaw

(State or country): Poland

14 Informant: Frank Wroblewski

(Address) 2104 Moyer St.

15 Filed: 1-9-1930 By: C. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 1-30 19

17 I HEREBY CERTIFY, That I attended deceased from 3-29-30 19 to 1-1-30 19

that I last saw him alive on 1-1-30 19

and that death occurred, on the date stated above, at 4-AM m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Hilliard, M. D.

(Address) 2214 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem

Date of Burial: April 2 1930

20 UNDERTAKER: Stephen J. Fratkowski INC.

ADDRESS: 1000 S. Kenwood Ave

that should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55690

CERTIFICATE OF DEATH.

24-001

E 55690

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST 11-24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Washington

(a) RESIDENCE NO. 342 W. Dolphin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... da. How long in U. S., if of foreign birth? — yrs. ..... mos. ..... da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1850 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ? Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?

(State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) ?

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

DEC 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-30

17 I HEREBY CERTIFY, That I attended deceased from 5-22, 1929, to 4-1, 1930,

that I last saw him alive on 4-1, 1930,

and that death occurred, on the date stated above, at 12-25 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, Sec

(Duration) ..... yrs. 1 mos ..... da.

CONTRIBUTORY (Secondary) Arteriosclerosis over

(Duration) ..... 1 yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

4-1, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Apr. 1 1930
UNDERTAKER Henry Sander & Sons Inc	ADDRESS Baltimore St & Broadway

THIS is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55691 — 90 E 55691

REGISTERED NO. 1250

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 344 E. 22nd St ST., 12th WARD)

2—FULL NAME Sarah Louisa Wilson

(a) RESIDENCE NO. 344 E. 22nd St ST., 12th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Widow of Samuel S. Wilson

6 DATE OF BIRTH (month, day, and year) March 14, 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	92	0	16 17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER Timothy Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Elizabeth Hesley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. E. P. A. Knighton

(Address) 344 E. 22nd St

15 Filed ... 19... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 31-30.

17 I HEREBY CERTIFY, That I attended deceased from Mar 25, 1930, to Mar 31-, 1930, that I last saw h- alive on Mar 30, 1930 and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Duration 3 yrs.
Heart block at 1.30 - Mar 31.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

. 19 (Address) 10 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cherrihill Grave

DATE OF BURIAL 4-2-30

20 UNDERTAKER J. Clay Burns Sons

ADDRESS Towson

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

135 V

CERTIFICATE OF DEATH

E 55692 REGISTERED NO. E 55692

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Franklin Sq. / ~~425~~ ST., 12 WARD)

2—FULL NAME Dr. Columbus M Brown

(a) RESIDENCE NO. 2729 Oak St ST., WARD (If non-resident give city or town and State)

(Usual place of abode) Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male X

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Brown

6 DATE OF BIRTH (month, day, and year): Sept 11, 1851

7 AGE: Years 78 | Months 6 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Cordelia Manning

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Anna Brown (Address) 2729 Oak St

15 Filed ..., 19... Registrar: HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1930, to April 1, 1930, that I last saw him alive on April 1, 1930, and that death occurred, on the date stated above, at 3:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Hypertrophied Prostate Gland (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) Arthur Rattenni, M. D.

4/1, 1930 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hanover Pa — DATE OF BURIAL: 4/3 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 E Pratt St

important. See instructions on back of certificates.

APR 1 1930

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 55693

55693 REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Mercy Hosp ST. 4-25 WARD)

2—FULL NAME Harry Stewart

(a) RESIDENCE NO. 645 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Anna A Stuart

6 DATE OF BIRTH (month, day, and year) Aug 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Lockhard Stuart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md

14 Informant Harry L Stewart (Address) 645 W Fayette St

15 Filed APR 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31/30

17 I HEREBY CERTIFY, That I attended deceased from 3/31/30, 19..., to 3/31, 19 30, that I last saw h alive on 3/31, 19 30, and that death occurred, on the date stated above, at 1120 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia,

Et. Cerebral Colic,

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? clinical & path.

(Signed) Henry D. Wilmot, M. D.

19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 4/3 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt St

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55694 ✓ E 55694

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3314 Tilest. ST., 26-25 WARD)

2-FULL NAME Marion M. Buckley.

(a) RESIDENCE NO. 3314 Tilest. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 24 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stock Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Martin J. Buckley

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Marie Le Brun

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co.
(State or country)

14 Informant Martin J. Buckley
(Address) 3314 Tilest St.

15 Filed APR 1 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 29, 19 30, to March 28, 19 30, that I last saw h[illegible] alive on March 28, 19 30, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum T.B.

(Signed) H. O'Neil Hamilton M. D.

4/1, 19 30 (Address) 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lawn Cemetery

DATE OF BURIAL April 2 1930

20 UNDERTAKER D. Lilly & Sons Inc.

ADDRESS 403 S. Monroe St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 55695

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH In the rear of

City of Baltimore: (No. 115 Winter St. St., 9-46 Ward)

2-FULL NAME George E. Grill.

(a) RESIDENCE NO. 1610 Carswell St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed or divorced HUSBAND of ~~xxx WIFE of~~ Lottie Grill.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	60	----	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.

(State or country)

PARENTS

10 NAME OF FATHER George Grill.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Lottie Grill. (wife)

(Address) 1610 Carswell St.

15 Filed ~~C. R. SIMPSON JONES M. D.~~ 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

3/31, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	April 3 1930
UNDERTAKER	ADDRESS
J. Howard Evans	21 E. Fa

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1930 C. R. SIMPSON JONES M. D.

Spec.—1-30—M. & T.—250 Bks.

E 55696 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55696

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 York Road WARD 7-46

2-FULL NAME Elizabeth S Spindler

(a) RESIDENCE No. 3205 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George L Spindler

6 DATE OF BIRTH (month, day, and year) March 11 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	0.	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm Fleischman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Fifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Adolph (Address) 3205 York Road

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31-30

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1919, to March 31, 1930, that I last saw h.r alive on March 31, 1930, and that death occurred, on the date stated above, at 11:25 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chr. Myocarditis

Chr. Int. Nephritis

(duration) 2+ yrs. mos. da.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. W. Bishop, M. D.

April 1, 1930 (Address) 501 Cheltenham Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL April 3 1930

20 UNDERTAKER Josiah Syfer

ADDRESS 1601 North Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

78 E 55697

E 55697

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nannie Boarman

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 22 Feb. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert Boarman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliz. Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Little Sisters of the Poor

(Address) Preston & Valley Sts

15 Filed 4-1, 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1/30

17 I HEREBY CERTIFY, That I attended deceased from 3/15, 1930, to 4/1, 1930, that I last saw h... alive on 3/31, 1930 and that death occurred, on the date stated above, at 1130 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

Senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Odema of Lungs (duration) 6 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernstein M. D.

4/1, 1930 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cemetery, Long Green Md

DATE OF BURIAL 4/3/1930

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55698

CERTIFICATE OF DEATH

91-002 E 55698

REGISTERED NO. 10-14

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. WARD)

2—FULL NAME Francis Tragesser

(a) RESIDENCE NO. Preston + Valley ST., WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Tragesser

6 DATE OF BIRTH (month, day, and year) Jan. 28th 1848

7 AGE	Years	Months	Days	If LESS than 1 day ~~hrs.~~ or ~~min.~~
	82	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Stissler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Stopfarm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Little Sisters of the Poor

(Address) Preston + Valley St.

15 Filed 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/1, 1930, to 3/31, 1930, that I last saw h alive on 3/30, 1930, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. T. Simmons Wood, M. D.

3/31, 1930 (Address) 1216 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 4/3/30, 19

20 UNDERTAKER Mary T. Tuthy Son

ADDRESS 1735 Harford Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55699

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 55699

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2567 Greenmount ST., 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jerrad Blatchley

(a) RESIDENCE NO. 2567 Greenmount ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lavina McCauley

6 DATE OF BIRTH (month, day, and year) 3-17-1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	0	13	— / —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work United Railways

(b) General nature of industry, business, or establishment in which employed (or employer) Supt. Route 6

(c) Name of employer Transportation

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Robert Blatchley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Margaret Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant George E. Blatchley

(Address) 1339 E. 31st St.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-30

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1929, to Mar 30, 1930, that I last saw h. alive on Mar 28, 1930 and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Coronar Dilatation

(duration) ... yrs. ... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Neptunitis - Hypertension

(duration) about 11 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) C. W. Cohen, M. D.

3/30, 1930 (Address) 1117 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 4/3/30. 19

20 UNDERTAKER Mary T. Putty Sons

ADDRESS 1735 Harford

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55700

CERTIFICATE OF DEATH

4+ E 55700

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1323 N. Caroline St. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mariano Vetri

(a) RESIDENCE NO. 1323 N. Caroline St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Phillipa Vetri

6 DATE OF BIRTH (month, day, and year) 8/10/1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer CHO

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. City

(c) Name of employer Sewage Dept

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Tony Vetri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. P. Vetri

(Address) 1323 N. Caroline St

15 Filed 1-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1/30.

17 I HEREBY CERTIFY, That I attended deceased from 3-23-30. to 4-1-1930.

that I last saw him alive on 3-31-1930

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Arteriosclerosis
Chronic Myocarditis.

(duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Romano, M. D.

4-1-1930 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 4/4/30.

20 UNDERTAKER Mary T. Pulls Sons

ADDRESS 1735 Hanover

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—350 Blks

Dr Franklin 9 E. Biddle St

E 55701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-524 × 90 E 55701

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Arundel Hotel Chas & Royal Ave. ST. 11-320 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helene Downing

(a) RESIDENCE NO. Hochetstown Md. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. 4 d. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Downing

6 DATE OF BIRTH (month, day, and year): Feb 3, 1864

7 AGE: Years 66 | Months 1 | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): New Orleans La

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. J. D. Crocker (Address) Washington D.C.

15 Filed ..., 19 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-31, 1930, to 4-1, 1930, that I last saw her alive on 4-1, 1930, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Coronary Failure

(duration) ? yrs. mos. da.

CONTRIBUTORY (Secondary): Myocarditis (duration) ? yrs. ? mos. ? da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None

(Signed) A. L. Franklin M. D.

, 19 (Address) 9 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md

DATE OF BURIAL: 4/2 19 30

20 UNDERTAKER: Wm Cook

ADDRESS: 1219 E Fayette St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55702

CERTIFICATE OF DEATH

179 E 55702

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (a) No. 216 E Barney ST. 24-34 WARD

2—FULL NAME Mary E. Koppelman

(a) RESIDENCE NO. 216 E Barney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 10 mos. 16 da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Koppelman

6 DATE OF BIRTH (month, day, and year) May 14-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Love

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eliz F. McCall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Beatrice Koppelman

(Address) 216 E Barney

15 Filed Apr 1 1930 C. HAMPSON JONES M D Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30-1930

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1930, to March 30, 1930, that I last saw her alive on March 30, 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Severe Burns 1/3 of body.

(duration) yrs. mos. 9 da.

CONTRIBUTORY (Secondary) Accident

Backed up against a heater (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) C Micheletti M. D.

Apl 1, 1930 (Address) 1279 Hillman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	April 2 1930
20 UNDERTAKER	ADDRESS
Maggard & Thomas	1111 Light St.

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55703

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55703

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 316 S. Lehigh ST. 26-37 WARD

2-FULL NAME Mary Elizabeth Fink

(a) RESIDENCE NO. 316 S. Lehigh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Fink

6 DATE OF BIRTH (month, day, and year) Dec. 18-1855.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Peter Ritz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Ritz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Fink (Address) 316 S. Lehigh St.

15 Filed APR 2 1930 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31-1930

17 I HEREBY CERTIFY That I attended deceased from Jan. 1926 to March 30 1930, that I last saw her alive on March 31st 1930, and that death occurred, on the date stated above, at 5.50 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Buccal Cavity (Tongue)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Degenerative Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Morris J. Schlimbinger M. D.

19 (Address) 1511 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz cemetery

DATE OF BURIAL Apr. 3 1930

UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170 E 55704

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 710 N. Lakewood Ave St., 7-12 Ward)

2-FULL NAME Nickolas Victor Jelusich

(a) RESIDENCE NO. 710 N. Lakewood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Kistner Jelusich

6 DATE OF BIRTH (month, day, and year) Nov 26/1859

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	70	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Sea Captain? ?
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Mary (Kistner) Jelusich
(Address) 710 N. Lakewood Ave

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot in Rt temple
(Suicide)

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. H. Watkins, M. D.

3/2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL Mar 31 30

20 UNDERTAKER Fred A. Klauser

ADDRESS 703 E Pratt

Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO. 55705

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 19-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Jerome Holmes

(a) RESIDENCE NO. 1620 W. Mulberry St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georganna Holmes

6 DATE OF BIRTH (month, day, and year) June 1861 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68?	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Records of Balto. City Hospitals

(Address)

15 Filed ....., 19 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-30

17 I HEREBY CERTIFY, That I attended deceased from 3-20-30, 19..., to 3-30-30, 19...

that I last saw h... alive on 3-30-30, 19...

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) ....yrs. 6 mos ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ?yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvey M. McLean, M. D.

3-31, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. auburn cemetery

DATE OF BURIAL 4-1 1930

20 UNDERTAKER Lotte Gross

ADDRESS 1408 E. ashland Ave

IMPORTANT: See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55706

CERTIFICATE OF DEATH

REGISTERED NO. E 55706

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pete Smalenickas

(a) RESIDENCE NO. 721 W Barre St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Litvania (State or country)

PARENTS

10 NAME OF FATHER G. Smalenckas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Litvania

12 MAIDEN NAME OF MOTHER Anne Klucute

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Litvania

14 Informant Anne Balunas

(Address) 826 S. Paca Street

15 Filed 19

THOMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31-1930

17 I HEREBY CERTIFY, That I attended deceased from 3/30/30, 1930, to March 31, 1930 that I last saw h[illegible] alive on March 31, 1930 and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

Probably (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastric Hemorrhage

Acute cardiac failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History, Physical Signs & Symptoms

(Signed) H. Glenn Speicher M. D.

3/31, 1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 2, 1930

20 UNDERTAKER John Grabliauskas ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55707

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55707

CERTIFICATE OF DEATH

45

REGISTERED NO. 25-72

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Deering Ave. ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriett Adele Kelley

(a) RESIDENCE NO. 1909 Deering Ave. ST., WARD (If non-resident, give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Kelley

6 DATE OF BIRTH (month, day, and year) July 12, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Manchester
(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert D. Grove

11 BIRTHPLACE OF FATHER (city or town) Abbottston
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Susan J. Miller

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania
(State or country)

14 Informant Mr. Wm. H. Kelley
(Address) 1909 Deering Ave.

15 Filed C. HAMPSON JONES, M. D. Registrar
4-2-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st 1929, to March 30th 1930

that I last saw her alive on March 30th 1930

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma
in small intestine
with metastases,
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maturation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes. Date of about 2 years ago

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Microscopic

(Signed) W. P. Byerly, M. D.

4/1, 1930 (Address) 3048 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown M.E. Church Cemetery

DATE OF BURIAL Apr. 2 1930

20 UNDERTAKER Sept 13 Cook

ADDRESS 1003 West Baltimore St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55708

99-002

E 55708

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Scott ST.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. King

(a) RESIDENCE NO. 713 Scott ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced (write the word)
Female	white	Widow

3a If married, widowed, or divorced
HUSBAND of (or) WIFE of John King

6 DATE OF BIRTH (month, day, and year) Oct 3 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles J. Schamberger (Address) 713 Scott St

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1st 1930, to March 31, 1930, that I last saw h... alive on March 30 1930 and that death occurred, on the date stated above, at 11.0 m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) 1 mos.

CONTRIBUTORY (Secondary) Senile Decay

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

4/1, 1930 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 3 1930
20 UNDERTAKER	ADDRESS
Jos Jourdens & Son	2178 Pa

APR 2 1930 HAMPSON LOWES, M. D.

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55709 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55709

74-00

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore Md.
CITY OF BALTIMORE: (No.) Thirty-first E Chas ST. 12-50 (WARD)

2-FULL NAME Francis James Cawley

(a) RESIDENCE NO. Homewood Apts. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 68 yrs. 7 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Florence Hoffman

6 DATE OF BIRTH (month, day, and year) July 24, 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self.

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER S. Hamilton Cawley
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md
12 MAIDEN NAME OF MOTHER Alice A. Pendegast
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Havre de Grace Md

14 Informant Adelaide Cawley
(Address) Walbert apartments

15 Filed ..... 19 ..... Registrar .....

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31st 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28th, 1930, to March 31st, 1930, that I last saw him alive on March 31st, 1930, and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Hemorrhage Medulla and Pons area
Bulbar palsy 9/5 (duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.
, 19 (Address) 2529 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL April 3rd 1930

20 UNDERTAKER Harry H. Eakins Sons Co

ADDRESS McCulloh & Orchard sts.

FROM A very important. See instructions on back of certificates.

R 2 - 1930 Pat

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55710

CERTIFICATE OF DEATH

129 E 55710

1—PLACE OF DEATH Good Shepherd General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1628 Lanvale ST. 16-23 WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Mc Cullers

(a) RESIDENCE NO. 1628 Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm mecullers.

6 DATE OF BIRTH (month, day, and year) June 18, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) at home. 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Elias Woodous

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wm. McCullers

(Address) 1209 W. Lanvale St

15 Filed APR 2 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29/30

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1930, to 3-29, 1930, that I last saw h[illegible] alive on 3-29, 1930 and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 4 mos da.

CONTRIBUTORY (Secondary) Nephritis (Cardio Renal biopsy) (duration) yrs. 4 mo da.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. H. Bo[illegible] Jr., M. D.

, 19 (Address) 1512 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 4/2 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 55711

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE, No. 1440 Richardson st ST. 24-35 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexandra Pietrowicz

(a) RESIDENCE NO. 1440 Richardson st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced WIFE of Kostanci Pietrowicz

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Karol Sobilgenski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Elizabeth Majeiczewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Kostanci Pietrowicz

(Address) 1440 Richardson st

15 Filed APR 2 1930 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-30

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1930, to April 1, 1930, that I last saw her alive on April 1, 1930 and that death occurred, on the date stated above, at 12:15 p m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) 1 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Brownschat, M. D.

41, 1930 (Address) 3037 Odonnell lv

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Cem. DATE OF BURIAL April 4 1930

20 UNDERTAKER George A. Weber ADDRESS 245 S. Ann st

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55712

CERTIFICATE OF DEATH

129 ✓

E 55712

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2639 Greenmount ST., 9-45 (WARD)

2—FULL NAME Emma C. Vondersmith

(a) RESIDENCE NO. 2639 Greenmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel S. Vondersmith

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 31

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER George S. Armstrong

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Daniel S. Vondersmith

(Address) 2639 Greenmount Ave

15 Filed ..., 19 ... Registrar

R 2-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to April 1, 1930, that I last saw h.er alive on April 1, 1930 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-vascular renal disease

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Jack J. Singer, M. D.

, 19 (Address) 1320 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 4/4 1930

20 UNDERTAKER J. M. Cook

ADDRESS 1217 E. Fayette St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55713

REGISTERED NO. E 55713

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument & Rutland St. (WARD) 13-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Jacob Ginsberg

(a) RESIDENCE NO. 2810 - Auchentoroly Terrace WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ginsberg

6 DATE OF BIRTH (month, day, and year)

7 AGE: 57 (Years / Months / Days)

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cap Mfg

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Henry Ginsberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Mary Ginsberg 2810 Auchentoroly Terrace

15 Filed 4-2 1930, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1930, to 4/2, 1930, that I last saw h/M alive on 4/2, 1930, and that death occurred, on the date stated above, at 1:55 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

Hypertension (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam & Lab

(Signed) [illegible] M. D.

4/2/1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: Hebrew Messing Ln

DATE OF BURIAL: 4/2 1930

ADDRESS

20 UNDERTAKER: Jack Louis 1409 E. Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 55714

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55714

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital St. 15-58 (WARD)

2-FULL NAME Jacob Hades Kades

(a) RESIDENCE No. 3706 Reisterstown Road WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rebecca G. Kades

6 DATE OF BIRTH (month, day, and year): April 10-1877

7 AGE — Years: 52 Months: 11 Days: 21 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wholesale Candy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Louis Kaden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Elda —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Rebecca G. Kades
(Address) 3706 Reisterstown Road

15 Filed APR 2-1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1930, to April 1, 1930,

that I last saw him alive on April 1, 1930,

and that death occurred, on the date stated above, at 10:35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) Antagon yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of March 24, 1930

Was there an autopsy? No Exploratory Laparotomy

What test confirmed diagnosis?

(Signed) Burgess Clark, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 4/2 1930

UNDERTAKER: Jacob Lewis — ADDRESS: 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55715 — 38 — E 55715

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (No. 7-12 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Eligha Pridgen

(a) RESIDENCE NO. 902 Belnord Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elnora Pridgen

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): S.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address): Balto. City Hospitals

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-30-30

17 I HEREBY CERTIFY, That I attended deceased from 3-28-30, 19, to 3-30-30, 19,

that I last saw h[illegible] alive on 3-30-30, 19,

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Syphilis of aorta & aortic insufficiency

(duration) 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Dave Padgett M. D.

3-31, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cherry Grove Cemetery — DATE OF BURIAL: 4-3-1930

20 UNDERTAKER: Chas. L. Bailey — ADDRESS: 1721 Pennsylvania Ave

FROM A very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 55716 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55716

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 162

City of BALTIMORE: (No. 306 S. Harris St. 9-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Richl

(a) Residence No. 306 S. Harris St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): March 12 '30

7-AGE: ....yrs. ....mos. ....ds.

If LESS than 1 day, 9 hrs. & 30 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: ....

(b) General nature of industry, business, or establishment in which employed (or employer): ....

(c) Name of employer: ....

9-BIRTHPLACE (city or town) (State or Country): Baltimore - Md

PARENTS.

10-NAME OF FATHER: Millon Rufus Richl

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Mina Alverta Ross

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md

14- (Informant): .... (Address): ....

15- Filed ... 1930 C. HAMPSON JONES, M. D. Registrar. Per ....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): March 13 1930

17- I HEREBY CERTIFY, That I attended deceased from 3-12-30 19.. to 3-13-30 19..

that I last saw h.. alive on 3-13-30 19..

and that death occurred, on the date stated above, at 1.30 m.

The CAUSE OF DEATH* was as follows: Bronchopneumonia disease of newborn

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? ....

Did an operation precede death? (Date of

Was there an autopsy? Yes - March 13-30

What test confirmed diagnosis? ....

(Signed) Fred B. Kemp Jones M. D

3/31 1930 (Address) Med. Staff.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Found Reward — DATE OF BURIAL: Undetermined

20-UNDERTAKER: .... ADDRESS: ....

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55717 ✓E 55717 E 55717

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

City of Baltimore: (No. Johns Hopkins Hospital St. 18-29 Ward)

2-FULL NAME Emma Long

(a) RESIDENCE NO. 113 S. Fulton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maurice J. Long

6 DATE OF BIRTH (month, day, and year) Sept 5 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	67	6	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pa.

PARENTS

10 NAME OF FATHER Jacob Kinsman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Elizabeth Kennedy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Carrie D. Campell
(Address) 113 S. Fulton Ave

15 Filed ... Registrar

Per ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1/30 '32

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Cerebro-Renal Disease

(duration) over 10 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) ... M. D.

4/2/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Clayton Pa.

DATE OF BURIAL 4/2 1930

UNDERTAKER Hoppe & Talley Fulton & Fayette

ADDRESS Mt Clayton Pa

Must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 2 - 1930 HAMPDEN JOINT

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55718

E 55718

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 N. Collington ave ST. 1-10 WARD)

2-FULL NAME Martha Jane Hayden

(a) RESIDENCE NO. 519 N. Collington Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Hayden

6 DATE OF BIRTH (month, day, and year) Nov. 10, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	75	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Banglow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Harriett Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. E. Smith

(Address) 519 N. Collington ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1928, to March 31, 1930, that I last saw h.. alive on March 31, 1930, and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Diabetes Mellitus

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron. Nephritis + Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Frank J. Ayd, M. D.

Mar 31, 1930 (Address) 2065 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Md	4/1/30
20 UNDERTAKER Ferge & Fahey Fisher Fayette	ADDRESS

APR 2, 1930 HAMPSON JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55719

CERTIFICATE OF DEATH

REGISTERED NO. E 55719

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital ST., (or) WARD)

2—FULL NAME Mr. George Robert Codling

(a) RESIDENCE NO. 2147 [redacted] Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced: [redacted]

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ellen E. Codling

6 DATE OF BIRTH (month, day, and year): May 6 1878

7 AGE: Years 51 | Months 10 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: George H. Codling

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mrs Ellen E. Codling

(Address) 2147 Hollins St

15 Filed APR 2 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/31/30

17 I HEREBY CERTIFY, That I attended deceased from 3/17, 1930, to 3/31, 1930, that I last saw h[redacted] alive on 3/31, 1930 and that death occurred, on the date stated above, at 11:40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. ? mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of d[redacted]: —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Jaundice

(Signed) Chas. E. Stacy, M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 4/3 1930

20 UNDERTAKER: Geo. A. Kelly Sullivan

ADDRESS: Fayette

important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55720 (1)

E 55720 (2)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1408 Kuper SHIEB St., 19-2-8 Ward)

2-FULL NAME Mrs Emma Schroeder

(a) RESIDENCE NO. 1408 Kuper St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Shelb

6 DATE OF BIRTH (month, day, and year): Mch 22 1871

7 AGE: Years 59 Months — Days 4 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Nil

9 BIRTHPLACE (city or town):

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town):

(State or country) Unknown

14 Informant: Mrs Jane Bell

(Address) 1408 Kuper St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930 to April 1 1930

that I last saw her alive on April 1 1930

and that death occurred, on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac-Regurgitation

(duration) X yrs. 6 mos. X da.

CONTRIBUTORY Chronic Bad. Nephritis

(Secondary)

(duration) 1 yrs. — mos. — da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no.

What tests confirmed diagnosis? Physical Exam etc

(Signed) L. Mac Morton M. D.

4/2/30 19 (Address) 888 N Luzerne Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

Date of Burial 4/4/30

20 UNDERTAKER Joseph Fahey

ADDRESS Luzerne & Lafayette

Instructions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55721

CERTIFICATE OF DEATH.

001 ✓

101 E 55721

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Harlem Ave S. 16-23 WARD

2-FULL NAME Susanna Davis

(a) RESIDENCE NO. 922 Harlem Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Richard Davis

6 DATE OF BIRTH (month, day, and year) Mch 5, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pr. George County Md

PARENTS

10 NAME OF FATHER Alex. Turner

11 BIRTHPLACE OF FATHER (city or town) Pr. Geo. Co (State or country) Md

12 MAIDEN NAME OF MOTHER — Ireland

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Lillian Peck
(Address) 922 Harlem Ave.

15 Filed APR 2 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1. 1930

17

I HEREBY CERTIFY, That I attended deceased from Mch. 26, 1930, to April 1, 1930,

that I last saw her alive on March 31, 1930,

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) H. Lee Ellis, M. D.

4/1, 1930 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chas S. Cooper — DATE OF BURIAL 4-3-1930

20 UNDERTAKER Mt Auburn Ave — ADDRESS 5 N. Eaddow St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 055722 — 57 — E 55722

REGISTERED NO. 17-50

1—PLACE OF DEATH: JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ____ ST. ____ WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sallie Beeler

(a) RESIDENCE NO. 320 E 25th ST., ____ WARD ____ (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Thomas L. Haston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Emma E. Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Nurses (Address) JOHNS HOPKINS HOSPITAL

15 Filed ____ G. HAYDON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 31/30

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1930, to March 31, 1930, that I last saw h[illegible] alive on March 31, 1930 and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis, Generalized
Diabetes Mellitus
(duration) 15 yrs. ____ mos. ____ da.

CONTRIBUTORY (Secondary): Coronary Occlusion
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 31st 1930

Was there an autopsy? Yes [illegible]

What test confirmed diagnosis? Operation & Autopsy

(Signed) George B. Finney M.D.

3/31 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: April 2 1930

20 UNDERTAKER: D. S[illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS 100 W. NORTH AVE.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55723

CERTIFICATE OF DEATH

10001 E 55723

1-PLACE OF DEATH

City of Baltimore: (No.) Found Rear 807 N. Stricker St. (Ward) 22

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(a) RESIDENCE Found Rear 807 N. Stricker St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 28th 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Baltimore

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant W. W. Schaefer
(Address) UNIVERSITY OF MARYLAND

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

APR 2 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ..... death on the day stated above.

(Inquest, autopsy or inquiry)

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular.

(Signed) H. C. Smith, M. D.

(Address) Asst Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL 19

ADDRESS

APR 2 - 1930

Commissioner Board of Health

Dr. W. H. Russell

Cor. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 2 1930

450

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55724

CERTIFICATE OF DEATH

167-001 ✓ E 55724

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ..... ST., 713 WARD)

2—FULL NAME Daisy Stand

(a) RESIDENCE NO. 1017 N. Caroline ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word):

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Mar. 25 1930

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
				10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Robert L. Stand

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Evelyn Schultz

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant ..... (Address) Johns Hopkins Hospital

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES M. D.

APR 2-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26, 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-25, 1930, to 3-26, 1930, that I last saw her alive on 3-26, 1930 and that death occurred, on the date stated above, at 3.15 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) G. Dengta M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JNS HOPKINS HOSPITAL

DATE OF BURIAL: APR 2 - 1930, 19

20 UNDERTAKER: Commissioner Health

ADDRESS

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55725

CERTIFICATE OF DEATH

161-09

E 55725

1—PLACE OF DEATH

Johns Hopkins Hospital.

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Gilmore

(a) RESIDENCE NO. 1220 N. Eden St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar. 24, 1930

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Robert Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Pearl Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: G. Kellogg

(Address) Johns Hopkins Hospital

15 Filed APR 2 1930, 19 [illegible] Registrar

C. HAMPSON JONES, M.D.
Commissioner Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-24-30

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 19 30, to 3-24, 19 30, that I last saw her alive on 3-24, 19 30 and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. Kellogg, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JNS HOPKINS HOSPITA

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS APR 2 - 1930

Important. See instructions on back of certificates.

(Aestor) ✓

Spec.—1-10-21—M&T—1500 Bks.

E 55726 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55726

CERTIFICATE OF DEATH. 44

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4000 Southern Avenue) 27-41 WARD

2-FULL NAME John T. Aestor

(a) RESIDENCE NO. 4000 Southern Avenue ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Aestor

6 DATE OF BIRTH (month, day, and year) 7/4-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Engineer 013

(b) General nature of industry, business, or establishment in which employed (or employer) B & O Railroad

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford County Md

PARENTS

10 NAME OF FATHER Andrew Aestor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Wm Lemmon (Address) 4000 Southern Avenue

15 [illegible] C. HAMPSON JONES, M. D. Registrar

2-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 20, 1930, to March 31, 1930, that I last saw h.. alive on March 30, 1930, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm Lemmon, M. D.

3-31, 1930 (Address) St Paul & Preston Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL 4 3 1930

20 UNDERTAKER Albert J Neitz ADDRESS 1606 h Chester St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55727

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55727

CERTIFICATE OF DEATH.

× 38

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Floyd Booker

(a) RESIDENCE No. 20? N. Eden ST., ... WARD Farmville Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Oct. 15, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER York Booker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lizzie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed 4-2 1930 12.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31-30

17 I HEREBY CERTIFY, That I attended deceased from 3-1-30, 19..., to 3-31-30, 19...,

that I last saw him alive on 3-31-30, 19...,

and that death occurred, on the date stated above, at 4:40 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis, tertiary

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis, Rt - 13 days

over (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of ——

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical: Autopsy

(Signed) Marvin M. McLeod, M. D.

4-2, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Farmville Va

DATE OF BURIAL Apr 3 1930

20 UNDERTAKER Saml. N. Chase Son

ADDRESS 1400 Mosher

TION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55728

CERTIFICATE OF DEATH

90 E 55728

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1640 St. Fulton Ave. Ward) 15-21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Hatton

(a) RESIDENCE NO. 1640 St. Fulton Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred about 75 yrs. (If non-resident give city or town and State) How long in U. S. if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: George C. Hatton

6 DATE OF BIRTH (month, day, and year): Oct 16 - 1844

7 AGE: Years 80 Months 5 Days 15 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 6

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Philadelphia Pa.

PARENTS

10 NAME OF FATHER: James Harris

11 BIRTHPLACE OF FATHER (City or town) (State or country): Wales.

12 MAIDEN NAME OF MOTHER: Sarah Philips

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wales.

14 Informant: Blythe L. Norman

(Address) 1614 N. Fulton Ave

15 Filed APR 2 - 1930

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Febry 9, 1930, to April 1, 1930, that I last saw h~~er~~ alive on Mch 31, 1930, and that death occurred, on the date stated above, at 1.55 m.

The CAUSE OF DEATH* was as follows:

Nephritis Acute

(duration) ✓ yrs. 8 mos. ✓ ds.

CONTRIBUTORY (Secondary) Myocarditis

✓ (duration) ✓ yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death?: ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical methods

(Signed) George C. Shannon, M. D.

4/1, 1930 (Address) 700 Fulton AVE

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Park — Date of Burial: April 4 1930

20 UNDERTAKER: H. W. Eller — ADDRESS: 1714 W Fork

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55729

HEALTH DEPARTMEN[redacted]TIMORE

E 55729

CERTIFICATE O[redacted]

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2313 Greenmount Ave St. 4 WARD 46)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Frederick Emrich

(a) RESIDENCE NO. 2313 Greenmount Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Margaret Emrich

6 DATE OF BIRTH (month, day, and year) July 8 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Private Police

(b) General nature of industry, business, or establishment in which employed (or employer) — —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER August Emrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Mannig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Margaret Emrich

(Address) 2313 Greenmount Ave

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31-30

17 I HEREBY CERTIFY, That I attended deceased from March-25, 1930, to March-31, 1930, that I last saw him alive on March-31-, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Rheumatism

(duration) 5 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sudden end

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) H Stanley Gosnell M. D.

Mar. 1930 (Address) 1100 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	April 3, 1930
20 UNDERTAKER	ADDRESS
Mary M Wiedefeld	501 E 22nd St

Important. See instructions on back of certificates.

R 2 - 1930 C. HAMPSON JONES, M

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55730

CERTIFICATE OF DEATH.

188-103 ✓ E 55730

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Gen. Hospital) (Street)

2-FULL NAME Alves Fitzhugh

(a) RESIDENCE NO. 4819 Norwood Ave. Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Ethel McClosky Fitzhugh

6 DATE OF BIRTH (month, day, and year) Nov. 26, 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work International Harvester Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer

9 BIRTHPLACE (city or town) Ill

(State or country)

PARENTS

10 NAME OF FATHER Dr. Wm H Fitzhugh

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Amelia Alves

13 BIRTHPLACE OF MOTHER (city or town) Ky

(State or country)

14 Informant Mrs. Ethel McC Fitzhugh

(Address) 4819 Norwood Ave

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows*

Accident in which he was driving car into trolley pole breaking it off & it falling upon auto

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. P. Frain M. D.

(Coroner)

April 9 1930 Address 29 39th St Edgewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? 4400 Block Liberty Heights Ave

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va Date of Burial April 3 1930

20 UNDERTAKER Wm Hickner Sons ADDRESS North Balto

Be sure the death is registered in the district in which it occurred. Every statement is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55731

E 55731

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2856 W. Lanvale St. 16-68 WARD)

2-FULL NAME Florence Virginia Hartan

(a) RESIDENCE No. 2856 W Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Samuel R. Hartan

6 DATE OF BIRTH (month, day, and year) Nov 10 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) Home 037
(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm McDowell

11 BIRTHPLACE OF FATHER (city or town) Boston
(State or country) Mass.

12 MAIDEN NAME OF MOTHER Johanna Peddecord

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mary Virginia Hartan Funeral Directing Home
(Address) 3716 Milford Ave

15 Filed Apr 2, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14th, 1930, to Mar. 31-, 1930, that I last saw her alive on Mar. 31st, 1930, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ..... yrs. ..... mos 15 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Isaac E. Dickson, M. D.

4-1-1930 (Address) 3055 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL Apr 3 1930

20 UNDERTAKER Thos J. Pedersen & Sons — ADDRESS N. & Pa

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55732

CERTIFICATE OF DEATH

74-08 V

E 55732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 400 N. Gilmor (St.) (Ward) 16-22

2-FULL NAME May C. Zugandt

(a) RESIDENCE NO. 400 N. Gilmor (St.) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmale

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Zugandt

6 DATE OF BIRTH (month, day, and year): May 4-1876

7 AGE: Years 53 | Months 7 | Days 29 | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 37
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Geo L. Schroder

11 BIRTHPLACE OF FATHER (city or town): Germany
(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Pfeiffer

13 BIRTHPLACE OF MOTHER (city or town): Baltimore Md
(State or country)

14 Informant: Edward Zugandt
(Address): 400 N. Gilmor

15 Filed ..., 19... Reg'd. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Sudden
(duration) ...yrs. ...mos.

CONTRIBUTORY (Secondary)
(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) Chas. J. Kirk, M. D.
(Address) Apr 4 1930 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Apr 4 1930

20 UNDERTAKER: Wm J Gruber Sons — ADDRESS: N. Y. Pa.

CHARLES JONES, M. D.

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

Steele

E 55733 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55733

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3016 Wylie Ave. ST., 15-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Steele.

(a) RESIDENCE NO. 3016 Wylie Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lary R. Steele.

6 DATE OF BIRTH (month, day, and year) March 7, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75.		25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired R. R.

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer. 0/3

(c) Name of employer

9 BIRTHPLACE (city or town) Pa. (State or country)

PARENTS

10 NAME OF FATHER James Steele.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Rebecca Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Miss. Irene V. Steele.

(Address) 3016 Wylie Ave.

15 Filed Apr 2 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1926, to Apr 2, 1930, that I last saw him alive on Apr 2, 1930, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. Present in 1928 mos. ds.

CONTRIBUTORY (Secondary) Heart block

(duration) 2 yrs. Present in 1928 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. Electrocardiogram

(Signed) Wm A Knitsler, M. D.

, 19 (Address) 12 Keyser St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Mem. DATE OF BURIAL April 4 1930

20 UNDERTAKER A. Howard Evans ADDRESS 38 E. Fort Ave

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

55734

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001

10 1 E 55734

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2324 Ettting St., 14-59 Ward)

2-FULL NAME Annie Sanders Miller

(a) RESIDENCE NO. 2324 Ettting St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fml

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Miller

6 DATE OF BIRTH (month, day, and year): Oct 28-1881

7 AGE: Years 48 | Months 5 | Days 3 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer:

9 BIRTHPLACE (city or town): Calvert Co
(State or country): Md

PARENTS

10 NAME OF FATHER: Billy Sanders

11 BIRTHPLACE OF FATHER (city or town): Calvert Co
(State or country): Md

12 MAIDEN NAME OF MOTHER: Mahorney

13 BIRTHPLACE OF MOTHER (city or town): Calvert Co
(State or country): Md

14 Informant: Wm Fuller
(Address): 2324 Ettting

15 Filed APR 3 1930 16 C. HAMILTON JONES, M. D. Registrar

17 Dist

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) ... M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wm. Auburn — DATE OF BURIAL: Apr. 3 1930

20 UNDERTAKER: Jesse H. Redden — ADDRESS 436 W. Biddle St

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55735

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55735

CERTIFICATE OF DEATH

32

1—PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Provident Hospital ST. 4-20 WARD)

2—FULL NAME William DeShields

(a) RESIDENCE NO. 636 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 2, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	1	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Joseph DeShields

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Cornelia Martin

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Joseph DeShields (Address) 636 Mosher St

15 Filed _____, 19__ _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31-30

17

I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to March 31, 1930, that I last saw h alive on March 31, 1930 and that death occurred, on the date stated above, at 6 PM.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) ____ yrs. 1 mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? clinical & autopsy

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas Cemetery	Apr-3 1930
20 UNDERTAKER	ADDRESS
Virginia A. Brooks	463 N. Carey St

important. See instructions on back of certificates.

C. HARRISON JONES, M. D.
APR 3 - 1930

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55736 ✓ E 55736

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH Levindale

CITY OF BALTIMORE: (No. Belvedere ave ST. 27-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Miriam Harris Katznelson

(a) RESIDENCE NO. Belvedere & Green Spring WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Abraham

6 DATE OF BIRTH (month, day, and year): 1836

7 AGE: Years 94 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Barnett Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Ettor —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Amelia Horowitz

(Address) Brighton Beach Apts

15 Filed ..... 19.. Registrar: C. HARRISON JONES, M.D. APR 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to April 2, 1930, that I last saw her alive on April 2, 1930, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 7 da.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) M Edmund Levin M. D.

April 2, 1930 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: April 3 1930

20 UNDERTAKER: S Lemmon Bro

ADDRESS: Eutaw St

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55737

91-00 2

E 55737

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 E. Fairmount ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine M. Betz

(a) RESIDENCE NO. 1906 E. Fairmount ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F Betz

6 DATE OF BIRTH (month, day, and year) Nov. 18 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Hartmann

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Machwet

13 BIRTHPLACE OF MOTHER (city or town) Ger. (State or country)

14 Informant Elizabeth E. Betz

(Address) 1906 E. Fairmount

15 Filed MAR 3 1930, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1930 to March 30, 1930

that I last saw her alive on March 21 1930

and that death occurred, on the date stated above, at 9 p.m.

The CAUSE OF DEATH* was as follows:

F. Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What was confirmed diagnosis?

(Signed) J C Hampton Jones, M. D.

19 (Address) 1435 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL April 4 1930

20 UNDERTAKER Jos J Stein & Son ADDRESS 36 Eutaw

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55738 — 11 2 VE 55738

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 914 St Barnabas St (Ward) 7th

2-FULL NAME Harry Cornish

(a) RESIDENCE NO. 914 St Barnabas St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	41	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Co

PARENTS

10 NAME OF FATHER John Cornish

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Lizzie Gillis
(Address) 30 1131 Carroll Ave

15 Filed APR 3 - 1930 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Error of diet

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.

(Address) [illegible] Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old Town Cem	4-3 1930
20 UNDERTAKER David Carton	ADDRESS 911 Gay St

Not should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55739

CERTIFICATE OF DEATH

90 ✓ E 55739

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 931 N. Mount St. 16-22 Ward)

2-FULL NAME Richard Parker

(a) RESIDENCE NO. 931 N. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 12 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	74		19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) A A Co Md
(State or country)

PARENTS

10 NAME OF FATHER Washington Parker

11 BIRTHPLACE OF FATHER (city or town) A A Co Md
(State or country)

12 MAIDEN NAME OF MOTHER Wilkinson

13 BIRTHPLACE OF MOTHER (city or town) A A Co Md
(State or country)

14 Informant Otho Smith
(Address) 931 N. Mount St

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Otho Smith, M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	4-3 1930
20 UNDERTAKER Daniel Carter	ADDRESS 916 Gay

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 3 - 1930 C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks.

E 55740 ✓ E 55740

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Brune ST. 17-16 (WARD)

2-FULL NAME Lula croyton Garrett

(a) RESIDENCE NO. 506 Brune ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Gamble

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Thornton Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Penn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Annie Garrett
(Address) 506 Brune St.

15 Filed APR 3 - 1930 C. HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-30

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1930, to April 1, 1930, that I last saw h[illegible] alive on April 1, 1930, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Colby, M. D.

, 19 (Address) 1629 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 4-3 1930

20 UNDERTAKER Daniel Easter

ADDRESS 916 Eutaw

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 ✓

E 55741

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 121 E. Broadway ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Goodman

(a) RESIDENCE NO. 121 E. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Goodman

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe-maker 08

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) [illegible] Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Irving Goodman

(Address) Boston, Mass

15 Filed [illegible] 19 [illegible] Registrar

Ref. [illegible]

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2-1930

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930 to April 2, 1930

that I last saw him alive on April 2, 1930

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 114 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 4/3 1930

20 UNDERTAKER Jack Louis 1409 E. Baltimore

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—1. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55742

CERTIFICATE OF DEATH

94 001

E 55742

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 625 St. Johns Rd. 4-27-53

2—FULL NAME Calvin Chesnut

(a) RESIDENCE NO. 625 St. Johns Rd. W.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Woods

6 DATE OF BIRTH (month, day, and year): Oct. 5, 1845

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
84	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance agent

(b) General nature of industry, business, or establishment in which employed (or employer): 67

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm. Chesnut

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Ann Rees

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware

14 Informant: Mr. W. Calvin Chesnut

(Address) 611 Ridgewood Road

15 Filed APR 4 1930 HARRISON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 2, 1930, that I last saw h his alive on April 2, 1930, and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with Right Hemiplegia (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis (duration) 2+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathology

(Signed) M. Gibson Kerlin, M. D.

3/3, 1930 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemy.	April 3, 1930
20 UNDERTAKER	ADDRESS
John C. Mitchell & Sons	1600 Eutaw St.

Important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55743

CERTIFICATE OF DEATH

× 101-001

E 55743

REGISTERED NO. 14-30

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Crowdent Hospital ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jefferson Clay

(a) RESIDENCE NO. 823 Eager St Spanson Pt WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cleary Clay

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Woodsdale (State or country) N.C

PARENTS

10 NAME OF FATHER Amos Clay

11 BIRTHPLACE OF FATHER (city or town) Woodsdale (State or country) N.C.

12 MAIDEN NAME OF MOTHER Mary Emma (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Wallie Taylor (friend)

(Address) 823 Eager St Spanson Point

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2-30

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1930, to April 2, 1930, that I last saw him alive on April 2, 1930 and that death occurred, on the date stated above, at 12 05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M St Clair, M. D.

4-2, 1930 (Address) Crowdent Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodsdale N. C.

DATE OF BURIAL April 6th 1930

ADDRESS

20 UNDERTAKER Samuel W. Stone Jr

Important. See instructions on back of certificates.

Spec.--2-29-28--L. F. S.--500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55744 91-002 E 55744

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 16-27

CITY OF BALTIMORE: (No. 1128 N. Vincent ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Dixon

(a) RESIDENCE NO. 1128 N. Vincent ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Moses Dixon

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (ar employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Catherine Thompson (Address) 1128 N. Vincent St

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1 30

17 I HEREBY CERTIFY, That I attended deceased from 1-9, 1930, to Apr 1, 1930 that I last saw her alive on Mar 31, 1930 and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease cantracted if not at place af death? —

Did an aperation precede death? no Data af —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Frank E. Wagner M. D.

4/2, 1930 (Address) 1006 Edmondson

*State the Disease Causing Death, ar in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, ar Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 3 1930
20 UNDERTAKER	ADDRESS
Wm. H. Fisher Sons	400 Maley

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 55745 HEALTH DEPARTMENT—CITY OF BALTIMORE 101 801

E 55745

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2534 Madison Ave ST.) 13-54 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hazelwood

(a) RESIDENCE NO. 2534 Madison Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Robert H. Hazelwood

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Boonsboro Co Md

PARENTS

10 NAME OF FATHER: Ed Keating

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Rose Hunter 2534 Madison Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 19 30

17 I HEREBY CERTIFY, That I attended deceased from May. 29, 1930, to May 31, 1930, that I last saw h alive on May 31, 1930, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Arterio Sclerosis of Heart (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Wm. L. Peters, M. D.

19 (Address) 1520 Eutaw Place, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashburn Cem.

DATE OF BURIAL: 4/3 1930

ADDRESS

20 UNDERTAKER: Byron Wright 1218 Mc Culloh St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55746

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55746

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5511 Gwynn Oak Ave. ST., 28-64 WARD)

2-FULL NAME Charles N. Emrich

(a) RESIDENCE NO. 5511 Gwynn Oak Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wh.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Emrich

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter Emrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mary E. Emrich (Address) 5511 Gwynn Oak Ave

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1930, to April 1, 1930, that I last saw him alive on April 1, 1930, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bacteria

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shatzen, M. D.

4/5, 1930 (Address) 3300 W. South Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	April 30
20 UNDERTAKER Josiah Eyler	ADDRESS [illegible]

TION is very important. See instructions on back of certificates.

2 - 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 55747 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ X 100-001

CERTIFICATE OF DEATH

REGISTERED NO. E 55747

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST 14-20 (WARD)

2—FULL NAME Helen Johnson

(a) RESIDENCE NO. Norman's Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 27, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Import

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norman
(State or country) Md

PARENTS

10 NAME OF FATHER Archie Johnson

11 BIRTHPLACE OF FATHER (city or town) Norman
(State or country) Md

12 MAIDEN NAME OF MOTHER Hettie Dozier

13 BIRTHPLACE OF MOTHER (city or town) Norman
(State or country) Md

14 Informant Hettie Johnson
(Address) Norman Md

15 Filed 1930 G. HARRY JONES, M. D. Registrar

R 3

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2-30

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 2, 1930 that I last saw h— alive on April 2, 1930 and that death occurred, on the date stated above, at 7 40 a. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

Rickets

[redacted]

(duration) yrs about 10 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

Sepsis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? clinical

(Signed) Carroll M. St Clair M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harmon Md.

DATE OF BURIAL 4/3/1930

ADDRESS

20 UNDERTAKER Chas. H. Holland 1401 Druid Hill Ave

important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55748 — CERTIFICATE OF DEATH. — REGISTERED NO. C E 55748

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1120 E. Bond St.) (WARD) 2-4

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Wiedenhoeft

(Residence in Baltimore: No. 1120 E. Bond St.)

St. 43 yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widower

6-DATE OF BIRTH, ... (Month) ..... (Day) 1867 (Year)

7-AGE: 63 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER: John Wiedenhoeft

11-BIRTHPLACE OF FATHER (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Wiedenhoeft

(Address) 35 N. Potomac St.

15- Filed ..... 191... C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 2, 1930 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Exhaustion (Duration) ..... yrs. ..... mos. 1 ds.

Witness ..... M. D. (Coroner) 1436 Bway (Address) .....

..... 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, First German Evan. | DATE OF BURIAL, April 4, 1930

20-UNDERTAKER J. Frank Mowen | ADDRESS 1000 N. Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55749

CERTIFICATE OF DEATH

45 E 55749

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 916 N Central ave ST. 10-14 WARD)

2—FULL NAME William H McGinnity

(a) RESIDENCE NO. 916 N Central ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 8 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry W McGinnity

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Schellenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant George R McGinnity

(Address) 916 N Central ave

15 Filed Apr 4 19 30 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1930

17 I HEREBY CERTIFY, That I attended deceased from July 15 19 30 to March 31 19 30, that I last saw h alive on March 31 19 30 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert Levy M. D.

4/1 19 30 (Address) 800 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL April 4 1930

20 UNDERTAKER Robt J Bunner

ADDRESS 1442 N Broadway

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55750 — 31 — E 55750

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) — REGISTERED NO.

CITY OF BALTIMORE: (No. 10-14 ST. Frame WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Blockson

(a) RESIDENCE NO. 876 McKim st. ST., WARD

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	37	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Theo. Blockson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) UNIVERSITY OF MARYLAND

15 Filed APR 3 - 1930 HAMILTON JONES, M. D. Registrar

Per 4506 RHK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1930, to March 28, 1930, that I last saw her alive on March 28, 1930, and that death occurred, on the date stated above, at 11.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

3-29, 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS APR 3 - 1930

For Wm. F. NORRIS

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55751

CERTIFICATE OF DEATH

199

REGISTERED NO. E 55751

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 16-22 Ward)

2-FULL NAME John Henry Brooks

(a) RESIDENCE NO. 1434 Harlem St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	C G	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys Brooks

6 DATE OF BIRTH (month, day, and year) Aug 20, 1902

7 AGE	Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
	27	8	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steward
(b) General nature of industry, business, or establishment in which employed (or employer) Steam Ship Work
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Jas Brooks

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Geo. Brooks
(Address) 1434 Harlem ave

15 Filed 1930 HAMILTON JONES, M. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2 1930

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an inquest
(Inquest, autopsy or Inquiry.)

thereon and from the evidenee obtained by said inquest (Inquest, autopsy or Inquiry) find that said deceased eame to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto Truck in which he was a rider struck Stand over by big Truck G W Br a Fracture Both

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Crushed Chest Fat Necr (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Scott & Osler

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) H J Braun, M. D.

4/3. 1930 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stone wall Lancaster Co Va	Apr 3 1930
20 UNDERTAKER John J Baker & Sons	ADDRESS 1315 Eight St.

Form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

234449 E 55752 — 36-004 — E 55752

Urology

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 1-27

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Dubel

(a) RESIDENCE NO. 1341 W Royal Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector of

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kate A Hettmansperger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed APR 3 1930 HAROLD N. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2-30

17 I HEREBY CERTIFY, That I attended deceased from 3-10-, 1930, to 4-2, 1930, that I last saw h[illegible] alive on 4-2, 1930, and that death occurred, on the date stated above, at 9:20 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of seminal tract and urinary bladder.

(?) Tuberculosis of Kidneys (?).

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia. Pyelonephritis.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) G. O. James, M. D.

(Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Apr 4 30

20 UNDERTAKER [illegible] & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS 103 W. NORTH AVE.

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55753 × 161-001 E 55753

E 55753

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST., 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby girl Gehr

(a) RESIDENCE NO. Westminster Carroll Co ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER [redacted] D. Edwin Gehr

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Grace King

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant D. Edwin Gehr
(Address) Westminster Md

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 2, 1930, that I last saw her alive on April 2, 1930 and that death occurred, on the date stated above, at 845 p m.

The CAUSE OF DEATH* was as follows:

Prematurity (5 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Elgin, M. D.

4/3, 1930 (Address) Church Home & Infirmary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Westminster Cemetary

DATE OF BURIAL APR 4 1930

20 UNDERTAKER J. Frances Reese

ADDRESS Westminster Md.

important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

E 5 5 7 5 4 HEALTH DEPARTMENT—CITY OF BALTIMORE E 5 5 7 5 4

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 306 E Madeira St. 12 WARD)

2-FULL NAME Margaret E Zorn

(a) RESIDENCE. No. 306 E Madeira St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late George Zorn

6 DATE OF BIRTH (month, day, and year): Jan 24-1860

7 AGE: Years 70 Months 2 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wechearior Eder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Rosanna Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Catherine M Zorn 306 E Madeira st

15 Filed APR 3 - 1930 19 H. HAMILTON GRIFFITH, M. D. Registrar

By RLC.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1930 to April 1 1930.

that I last saw h alive on March 31 1930.

and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pneumococcus Lobaris

(Signed) James R Crossland M. D.

(Address) 1729 E Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemet

DATE OF BURIAL: April 5 1930

20 UNDERTAKER: Lellyo Zieler INC

ADDRESS: 407 So Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55755

E 55755

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3810 Frankford Ave ST., 27-43 WARD)

2-FULL NAME Ellen Rose

(a) RESIDENCE NO. 3810 Frankford Ave ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late John Rose

6 DATE OF BIRTH (month, day, and year) Feb 25th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jeremiah Finney

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Ann Bailey

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Anna M. Hamill Daughter

(Address) 3810 Frankford Ave

Filed APR 3 1930 HAMILTON JONES, M. D. Registrar

By RLP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1928, to March 31, 1930.

that I last saw h. alive on March 31, 1930.

and that death occurred, on the date stated above, at 4 20 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 2 yrs. mos. dys.

CONTRIBUTORY (Secondary) Cardiac Vascular Renal (duration) unknown yrs. 6 mos. dys.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO. Date of

Was there an autopsy? NO.

What test confirmed diagnosis? Phys Exam

(Signed) J S Harding M. D.

, 19 (Address) 4810 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL April 4 1930

ADDRESS 409 S. Wolfe St

20 UNDERTAKER Lilly & Zeiler Sucs

SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55756

CERTIFICATE OF DEATH

24-001

E 55756

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at the

City of Baltimore: (No. South Baltimore General Hospital St., 12-30 Ward)

2-FULL NAME William Bailey.(C)

(a) RESIDENCE NO. 12 N. York St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September 15, 1878.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Rosa Bailey.(C)
(Address) 12 N. York St.

15 Filed 4-5 1930 C. HAMILTON JONES, M. D. Registrar
Per Pitt

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? York & Hanover Sts. April 1, 1930

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

4/2, 1930 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 4/5 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1398 W Hamburg St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PNS - 1930

Cor.—10-10-29—A Co.—100 Bks.

Wm D Doherty

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55757

CERTIFICATE OF DEATH

188-103 ✓ E 55757

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp. St., 3-4 Ward)

2-FULL NAME Wm D. Doherty

(a) RESIDENCE NO. 1617 Bank St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July - 24 - 1922

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
7	8	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) School
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Jas Doherty

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Eliz Lipinski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Mary Dougherty Mrs
(Address) 1617 Bank St

15 Filed ... 19... HAMPSON JONES, M. D. Registrar
By ...

APR 3 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck and knocked down by moving auto while running accross street

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in front of 317 Bway

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. J. France, M. D.

4/2 1930 (Address) 2939 W. Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	4 5 1930
20 UNDERTAKER	ADDRESS
Weber	421 E Chester

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1 30—M. & T.—250 Bks.

E 55758 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-9E 55758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2605 Orleans St. 16-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland L. Feikler Jr

(a) RESIDENCE No. 3029 Brighton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Oct 2/1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Roland L. Feikler Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Maud Feigley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Roland L. Feikler Sr

(Address) 2605 Orleans St

15 Filed APR 3 1930 19 C. HAMPSON LEWIS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2/30

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to April 2, 1930, that I last saw him alive on April 2, 1930, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Otitis Media Sub-

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Loring Julian M. D.

4/3, 1930 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Apr 4 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & F.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55759

CERTIFICATE OF DEATH.

101-001 55759

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4807 Arabia Av ST. 27-44 WARD

2-FULL NAME Bertha M. Yeager

(a) RESIDENCE No. 4807 Arabia av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Henry Yeager

6 DATE OF BIRTH (month, day, and year) May 7/78

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Henry Ahrens

11 BIRTHPLACE OF FATHER (city or town) (State or country) German

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) German

14 Informant Henry Yeager

(Address) 4807 Arabia av

15 Filed APR 3 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/30.

17 I HEREBY CERTIFY, That I attended deceased from 3/27, 1930, to 4/2, 1930, that I last saw h[illegible] alive on 4/2, 1930, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Kyle W. Holley, M. D.

, 19 (Address) 5703 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL Apr 5 1930

ADDRESS 2016 Orleans St

20 UNDERTAKER Philip Herwig D

CHECK OF ITEMS 1 TO 20 IN THIS CERTIFICATE, AND SEE THAT ALL MAY BE PROPERLY ANSWERED. ATTENTION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55760

CERTIFICATE OF DEATH.

161 E 55760

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3110 b Clearview Ave St.) 7-43 (WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unnamed Kirschner

(Residence in Baltimore: No. 3110 b Clearview Ave St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F. | 4-COLOR OR RACE, W. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) ✓

6-DATE OF BIRTH, April ✓, 1930 (Month) (Day) (Year)

7-AGE, ✓ yrs. ✓ mos. ✓ ds. If LESS than 1 day, ✓ hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ralph Kirschner

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Emma Good

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed APR 3 1930 1930 Per C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April ✓, 1930 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr ✓ 1930, to Apr ✓ 1930, that I saw h ✓ alive on April ✓ 1930, and that death occurred, on the date stated above, at 6.35 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) Life yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(Duration) yrs. mos. ds.

(Signed) Ralph Lothrop M. D.

Apr 3, 1930 (Address) 726 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Dr Rohrer State Board | DATE OF BURIAL, ..., 1930

20-UNDERTAKER Commissioner Health. | ADDRESS APR 3 - 1930

Per Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 3 - 1930 1502

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55761

CERTIFICATE OF DEATH

90 E 55761

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4612 Park Heights Ave Ward 27-56)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Foltz

(a) RESIDENCE NO. 4612 Park Heights Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B. Foltz

6 DATE OF BIRTH (month, day, and year) May. 12-1854

7 AGE Years 75 Months 10 Days 21

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 145

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Dealer.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER Jacob Foltz

11 BIRTHPLACE OF FATHER (City or town) Balto. Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Woodley

13 BIRTHPLACE OF MOTHER (city or town) Pa

(State or country)

14 Informant Mrs. Anna B. Foltz

(Address) 4612 Park Heights Ave.

15 Filed 3 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2. 1930

17 I HEREBY CERTIFY, That I attended deceased from about 2 yrs. ago 19 to April 2 1930, that I last saw h alive on April 1 1930, and that death occurred, on the date stated above, at 10 0 m.

The CAUSE OF DEATH* was as follows:

Chronic myocardial insufficiency

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs & symptoms

(Signed) J. T. Thennell, M. D.

April 3. 1930 (Address) 3310 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery Date of Burial Apr. 5 1930

20 UNDERTAKER George L. Schmidt ADDRESS 210 Fulton Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55762 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55762

37

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST. 9-18 WARD)

2-FULL NAME Julia Boyer

(a) RESIDENCE NO. 1506 Aisquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bruce Boyer

6 DATE OF BIRTH (month, day, and year) Jan. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer ....

9 BIRTHPLACE (city or town) St. George's Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Bruce-William

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country) Unknown

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed APR 3 1930, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2-30

17 I HEREBY CERTIFY, That I attended deceased from 3-17-30, 19...., to 4-2-30, 19....,
that I last saw her alive on 4-2-30, 19....,
and that death occurred, on the date stated above, at 11:10 A.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ... yrs. over 14 mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. over 14 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of ....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Marion M. McLean, M. D.

4-3, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	April 5 1930
20 UNDERTAKER A. Howard Evans	ADDRESS 88 S. Fulton Ave

ATTENTION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55763

CERTIFICATE OF DEATH

90 ✓ E 55763

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 517 W. Biddle St. 17-24 Ward)

2-FULL NAME Elizabeth Brown

(a) RESIDENCE NO. 517 W Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day and year): 1858

7 AGE: Years 72 | Months | Days | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer

9 BIRTHPLACE (city or town): L. Co.
(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Unknown

14 Informant: Edward Shelton
(Address): 517 W Biddle St

15 Filed APR 4 1930 19 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 3rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Schenck, M. D.

(Address) Coroner

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: April 4 1930

20 UNDERTAKER: Chas. E. Franck — ADDRESS: 802 Madison Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55764

CERTIFICATE OF DEATH.

38 E 55764

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp × 15-108 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Eleanor Frank

(a) RESIDENCE NO. 2500 W. North Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 16 02

7 AGE: Years 27 Months 9 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer): Sisters

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Allentown Pa

PARENTS

10 NAME OF FATHER: Wm E Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country): Allentown Pa

12 MAIDEN NAME OF MOTHER: Elsie Strathmore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Allentown Pa

14 Informant (Address): Hospital Record.

15 Filed APR 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/1/30 19

17 I HEREBY CERTIFY, That I attended deceased from 4/1/30, 19, to 4-1-30, 19, that I last saw her alive on 4-1-30, 19, and that death occurred, on the date stated above, at 6 0½ P.M.

The CAUSE OF DEATH* was as follows:

Tentorium Tear

Cerebral Hemorrhage

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Appendicitis

(duration) yrs. mos. 4 Sh ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 3/4/30

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) John A Finnegan M. D.

(Address) Md Gen Hosp

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery

DATE OF BURIAL: Apr 4 1930

20 UNDERTAKER: Wm Routson

ADDRESS 2238 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55765

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55765

CERTIFICATE OF DEATH

24-001

REGISTERED NO. 24-33

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1288 Riverside Ave ST. (If death occurred in a hospital or institution, give its NAME instead of street and number.) (WARD) 24th

2—FULL NAME Charles Straub

(a) RESIDENCE NO. 1288 Riverside Ave ST., 24th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Straub

6 DATE OF BIRTH (month, day, and year): Dec 8th 1847

7 AGE: Years 82 | Months 3 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs Joseph Straub

(Address) 1116 Battery Ave

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-2nd 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15, 1930 to Apr. 2, 1930 that I last saw him alive on Apr. 2, 1930 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. 17 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. C. L. Campbell M. D.

4/3, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A & Co.

DATE OF BURIAL: 4-5th 1930

20 UNDERTAKER: E & B. Harle

ADDRESS: 1156 West St.

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

Dr Fenby 1223 N. Carolina

E 55766 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 55766

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2636 Harford Ave (St.) 9-46 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Baner Sr.

(a) RESIDENCE No. 2636 Harford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Baner

6 DATE OF BIRTH (month, day, and year) Oct 21. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lieut USA

(b) General nature of industry, business, or establishment in which employed (or employer) Custom Service

(c) Name of employer U S Govt

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Baner

11 BIRTHPLACE OF FATHER (City or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Germany

14 Informant John A Baner Jr

(Address) 2312 Arlington Ave

15 Filed ..... 19 C. HARRISON JONES, M. D. Registrar

R 4-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2. 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov. 12 - 1929 to Apr. 2 - 1930.

that I last saw him alive on April 2 - 1930

and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) — yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) — yrs. 5 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

4/3/1930 (Address) 1223 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 4/5 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55767

HEALTH DEPARTMENT—CITY OF BALTIMORE

160 ✓ E 55767

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 733 Harford Ave ST. 10-W (WARD)

2—FULL NAME George Cutsey

(a) RESIDENCE NO. 733 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 4-1-30

7 AGE — Years: ..... Months: ..... Days: 2 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Alonzo Cutsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): S.C

12 MAIDEN NAME OF MOTHER Mamie Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S.C

14 Informant Mamie Griffin

(Address) 733 Harford ave

15 Filed APR 4 1930 HUMPHREY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 4-30

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1930, to Apr 4, 1930, that I last saw h— alive on Apr 4, 1930, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Octenic Neonatorum

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) R O Galetin, M. D.

4/3, 1930 (Address) 1125 Pine St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: april 4 1930

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 orleans st

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55768

38 E 55768

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp (Street) (WARD) 18-7

2-FULL NAME James Brown

(a) RESIDENCE NO. 618 Sarah Ann St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 1st 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	37		30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Ida Brown (Address) 618 Sarah ann st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/31 1930

17 I HEREBY CERTIFY, That I attended deceased from ~~Dec~~ 3/30, 1930, to 3/31, 1930, that I last saw him alive on 3/31, 1930 and that death occurred, on the date stated above, at 6:45 P m

The CAUSE OF DEATH* was as follows:

Abdominal aortic aneurysm eroding into Spinal column

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 3/30/30

Was there an autopsy? No Exploratory

What test confirmed diagnosis? Clinical & operative

(Signed) S. A. Alessi, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ellerdge V. A. DATE OF BURIAL April 3 1930

20 UNDERTAKER A. Jones ADDRESS 11 S. Gilson

HARRY JONES, M. D.

R 4-1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important

Spec.—2-29-28—I. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55769

CERTIFICATE OF DEATH

31 ✓ E 55769

REGISTERED NO. 21-29

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1159 Mash Blod ST.) (.....WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard Mallbright.

(a) RESIDENCE NO. 1159 Mash Blod ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of May allbright

6 DATE OF BIRTH (month, day, and year) Nov 23-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hunter

(b) General nature of industry, business, or establishment in which employed (or employer) Waterlaier

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER Rose allbright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Laura Odendorf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs allbright

(Address) 1159 Mash Blod

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/30

17 I HEREBY CERTIFY, That I attended deceased from 3-16-, 1930, to 4-3-, 1930

that I last saw h.. alive on 4-3-1930

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation.

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchitis due to Edema (duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Howard Davis, M. D.

..... 19 (Address) 1159 Mash Blod

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL April 7 19 30

20 UNDERTAKER Thos Fields ADDRESS 1200 N Lombard

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Time of burial extended to 4-9-30.

E 55770

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55770

J. Hamilton Stumpf Asst. Com of Health

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General St. Ward (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. P. Manning Godfrey

(a) RESIDENCE NO. Apt. B. 611 Gorsuch Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~or WIFE~~ of Irving Leonard

6 DATE OF BIRTH (month, day, and year) 3/5/1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min
	31	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physical Instructor

(b) General nature of industry, business, or establishment in which employed (or employer) School System

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) St Paul Minn

PARENTS

10 NAME OF FATHER Percy D. Godfrey Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hampton N. H.

12 MAIDEN NAME OF MOTHER Marion N Lawton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Paul Minn

14 Informant Minnie Godfrey (Address) 611 Gorsuch Ave

15 Filed APR 4 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1930, to March 31, 1930, that I last saw him alive on March 31, 1930 and that death occurred, on the date stated above, at 9.35 P m

The CAUSE OF DEATH* was as follows:

Aplastic Anemia

(duration) ... yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & Clinical

(Signed) J. I. Corbyn M. D.

, 19 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul Minn — DATE OF BURIAL 4/9 1930

UNDERTAKER Beaumier Cook — ADDRESS 1219 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 5577A

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-09 55771

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 2-4 Ward)

2-FULL NAME Adam Miller

(a) RESIDENCE NO. 1720 Mccans St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Miller

6 DATE OF BIRTH (month, day, and year) Apr. 10, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
38 39		11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Kate Minich

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Robert Brooks
(Address) Calhoun Hollins

15 Filed APR 4 - 1930 19 C. HAMPDEN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Ex Lausdow

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Autopsy

(Signed) H. C. Hodges, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U.S. National Rd	4/6 1930
20 UNDERTAKER Robert Brooks Son	ADDRESS Calhoun Hollins

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

B 55772

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 55772

CERTIFICATE OF DEATH

33

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 5-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Gold

(a) RESIDENCE NO. 1232 Guilford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Dr. to.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 4 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-30

17 I HEREBY CERTIFY, That I attended deceased from 3-5-, 1930, to 4-1-, 1930, that I last saw h alive on 4-1-, 1930 and that death occurred, on the date stated above, at 6⁰⁵ P. m.

The CAUSE OF DEATH* was as follows:

General malnutrition occasioned by chronic Tuberculous pedria suppurative Decubitus with associated unfavorable course. Tuberculous Peritonitis. (duration) yrs. 3 mos. 1 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? in general life.

Did an operation precede death? No Date of 3-5-30

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) H. S. Everett, M. D.

4/2, 1930 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemty

DATE OF BURIAL 4/4 1930

20 UNDERTAKER Byron Wright

ADDRESS 1219 N. Eldeny

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 55773

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital) (WARD) 12-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Master Harvey Gilbert, Jr.

(a) RESIDENCE NO. Savannah Ga. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced BUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) April 27, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	13	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savannah, Ga.

PARENTS

10 NAME OF FATHER Harvey J. Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Edith Bryon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Mr. Harvey Gilbert

(Address) Savannah Ga.

15 Filed APR 4 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1930.

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to April 4, 1930

that I last saw him alive on April 4, 1930

and that death occurred, on the date stated above, at 6:25 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

" Endocarditis

& Anasarca.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Decompensation (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Savannah, Ga.

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) Albert R. Wilkerson, M. D.

(Address) Union Mem. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Savannah Ga.	4 4 19 30
20 UNDERTAKER Chas. P. Braud & Son	ADDRESS 111 W. Bay St. Royal Ga.

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55774

CERTIFICATE OF DEATH.

57 V E 55774

REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument St. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Robinson

(a) RESIDENCE NO. 2132 E. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Toba Robinson

6 DATE OF BIRTH (month, day, and year) 3-10-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 215

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Tobie Robinson (Address) 2132 E Baltimore

15 Filed APR 4 - 1930 C. HAWKINS JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1930, to 4/3, 1930,

that I last saw h/ alive on 4/3, 1930,

and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia & Diabetes mellitus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. J. Cohen, M. D.

4/3, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 4/4 1930

UNDERTAKER Jack Lewis ADDRESS 1439 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55775

CERTIFICATE OF DEATH.

90 E 55775

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rose Nachlas

(a) RESIDENCE NO. 2312 Eutaw Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hertz Nachlas

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Blutkern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Dr Nachlas (Address) Eutaw Place

15 Filed [illegible] 19 [illegible] Registrar

C. HAMPTON JONES, M. D.

APR 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-21- 1930, to 4-4 1930,

that I last saw h alive on 4-4 1930,

and that death occurred, on the date stated above, at 2.a m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Angina Pectoris

Chronic Myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B Golen, M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 4/4 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eastern Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55776

CERTIFICATE OF DEATH.

90 M 55776

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST., 7-13 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Waters

(a) RESIDENCE NO. 1603 Millman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Waters

6 DATE OF BIRTH (month, day, and year): Dec. 28, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N.C.

PARENTS

10 NAME OF FATHER: Shepperd Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.C.

12 MAIDEN NAME OF MOTHER: Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.C.

14 Informant: Records of

(Address): Balto. City Hosp.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-1-30

17 I HEREBY CERTIFY, That I attended deceased from 3-2-30, 19..., to 4-1-30, 19..., that I last saw him alive on 4-1-30, 19..., and that death occurred, on the date stated above, at 2:15 P a.m.

The CAUSE OF DEATH* was as follows: Myocarditis, chronic Toxemia

(duration) over 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical: Autopsy

(Signed) Marvin W. McLane, M. D.

4-2, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary cemetery	Apr 4, 1930
20 UNDERTAKER: Mrs. R. A. Elliott	ADDRESS 1720 Ashland Ave

C. HARRISON JONES, M. D.

IMPORTANT: See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55777 3 1√E 55777

1-PLACE OF DEATH Baltimore City Hospitals (ST. 2-2-30 WARD) REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gary Burrows

(a) RESIDENCE NO. 505 Lee st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie Burrows

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Henry Burrows

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Recores (Address)

15 Filed APR 4 - 1930 19 C. Haywood JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1930, to April 1, 1930, that I last saw him alive on April 1, 1930, and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas G Burnes Jr M. D.

4-2-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cemetery	Apr. 4 1930
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1726 Ashland Ave

TION is very important See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 55778

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51 ✓ E 55778

REGISTERED NO. 2691

1-PLACE OF DEATH

City of BALTIMORE: (No. 107 W York St. 12-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Brown

(a) RESIDENCE NO. 107 W York St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert Brown

6 DATE OF BIRTH (month, day, and year): 2 11 96

7 AGE: Years 33 Months 1 Days 22 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Churchfield, Md

(State or country)

PARENTS

10 NAME OF FATHER: William J. Ward

11 BIRTHPLACE OF FATHER (City or town): Hopewell Md

(State or country)

12 MAIDEN NAME OF MOTHER: Hattie Johnson

13 BIRTHPLACE OF MOTHER (city or town): Churchfield Md

(State or country)

14 Informant: Mattie Ward

(Address) 107 w york st

15 Filed ..... 19 .....

APR 4 - 1930

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-3-30

17 I HEREBY CERTIFY, That I attended deceased from March 16 1930 to April 3 1930

that I last saw h[illegible] alive on April 1 1930

and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Cirrhosis Rheumatism Heart Disease

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical

(Signed) W. Atwell Jones, M. D.

, 19 (Address) 123 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT Auburn Ct — Date of Burial: April 5 1930

20 UNDERTAKER: W. A. Brown & Son — ADDRESS: Penn. Mondpl

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 55779

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2236, E, Hoffman ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph L, McKee

(a) RESIDENCE NO. 2236 E, Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 46) mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor R, McKee

6 DATE OF BIRTH (month, day, and year) March 23 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	46		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic do

(b) General nature of industry, business, or establishment(in which employed (or employer) Chemical Works

(c) Name of employer Mutual Chemical Co

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER William McKee

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York N,Y.

12 MAIDEN NAME OF MOTHER Margaret Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant(Mary Conway

(Address) 2236 E, Hoffman St

15 Filed APR 4 - 1930 19 R P K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Depar 2/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 30. 19 30. to Depar 2. 19 30

that I last saw h alive on Depar 2. 19 30

and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Myocarditis + Chronic Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Edmund Kelly M. D.

19 (Address) 1009 N Lumford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Balto City	April 5 1930

20 UNDERTAKER Frank V. Pisciotta ADDRESS 2818 E. Balto St

Important. See instructions on back of certificates.

Spec.—5-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55780 — NOV — E 55780

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2422 Stockton ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Wilson

(a) RESIDENCE NO. 2422 Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Widower

3a If married, widowed, or divorced (or) WIFE of Josephine Wilson Nee

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oyster Shucker

(b) General nature of Industry, business, or establishment in which employed (or employer) Oyster Packing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER David Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Rachel Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant Frederick Wilson (Address) 1685 E. Monument

15 Filed ..... 19 ..... Registrar

C. HAMILTON JONES, M. D.

R 4-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/26 .1930. to 4-2 .1930.

that I last saw h alive on 4-2 .1930

and that death occurred, on the date stated above, at 7.45 a m

The CAUSE OF DEATH* was as follows:

Abscess of Brain

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Lysterpoisoning 1 yr ?

(duration) 1 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J J McKee M. D.

4-4, 1930 Address 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetry — DATE OF BURIAL april 6 1930

20 UNDERTAKER Edward Bryan — ADDRESS 1691 orleans st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55781

CERTIFICATE OF DEATH

187 ✓ E 55781 007

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Western Maryland Grain Elevator Port Covington. St., 26-2 Ward)

2-FULL NAME George F. Metzger.

(a) RESIDENCE NO. 211 S. East St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 29 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma Metzger.

6 DATE OF BIRTH (month, day, and year) September 5, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	6	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machine man 031
(b) General nature of industry, business, or establishment in which employed (or employer) W.Md. Grain Elevator
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George F. Metzger.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Eva M. Zegelein.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Emma Metzger. (wife)
(Address) 211 S. East St.

15 Filed APR 4 - 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the skull, crushed about the body. Caught in revolving belt of machinery. Occidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Reinhardt, M. D.

4/4, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	April 7, 1930
20 UNDERTAKER	ADDRESS
George W. Finkler	1737 E. Eager St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55732 — 14-001 — E 55732

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1925 W. Lombard A (Mollie) St. 20-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Daniels

(a) RESIDENCE NO. 1925 W. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Daniels

6 DATE OF BIRTH (month, day, and year) December 25, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Parrish

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan R. Metcalf

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Lillian M. Willingham

(Address) Oella, Md.

15 Filed C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Goiter 4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Harold Brooke M. D.

(Coroner)

4/3, 1930 (Address) 3601 Third St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

Date of Burial Apr. 5 1930

20 UNDERTAKER Joseph Cook

ADDRESS 1003 West Baltimore

All should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R4 1930

Cor.—12-9-25—A Co—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55783 | 188-103 E 55783

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. West Baltimore Hospital St. 15-61 Ward)

2-FULL NAME John Henry Collison

(a) RESIDENCE NO. 3515 Fairview Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Amanda H. Collison

6 DATE OF BIRTH (month, day, and year) Sept. 11, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	66	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Oyster Packer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER John H. Collison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Alice Brierwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mr. John H. Collison, Jr., Tudor Apartments

15 Filed APR 4 1930 19 C. HARRISON Registrar

Mar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 2, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry and from my own investigation, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Struck & Killed down by Motor auto

Ac (duration) Instant Shock mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) L.D. Paine M. D. (Coroner)

4-4 1930 (Address) Bayne & Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Collision Ave & Poplar Street

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: April 5 1930

20 UNDERTAKER: B. John & Denny — ADDRESS: 7 N. Eutaw

Be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55784

CERTIFICATE OF DEATH

12-00

E 55784

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 N. Smallwood ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilmer G. Harple

(a) RESIDENCE NO. 1822 N. Smallwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Coal laboring work

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Lancaster Co. Pa.

PARENTS

10 NAME OF FATHER John Harple

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary Schaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs Laura Becker

(Address) 1708 Hillcrest Rd.

15 Filed ..... 19.. C. HILLYARD, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr. 3/30

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1929, to apr. 3rd 1930.

that I last saw h alive on apr. 2nd 1930

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Val. Dis. of Heart, Coronary Arterial Thrombosis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden failure of heart action

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of

Was there an autopsy? Trouble

What test confirmed diagnosis? Examination

(Signed) E. Hyman M. D.

4/3. 1930 (Address) 1605 N Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Camp Chapel Cemetery	April 7 1930
20 UNDERTAKER	ADDRESS
Frederick Lazenby Sons	Fulleston

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55785

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55785

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1618 Harford ave ST. 9-18 (WARD)

2-FULL NAME Frank Hartman

(a) RESIDENCE NO. 1618 Harford ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if of foreign birth? 78 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Susie Hartman

6 DATE OF BIRTH (month, day, and year) Dec. 16 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Shoe

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe maker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Katie Jones

(Address) 1618 Harford ave

15 Filed APR 4 - 1930 19 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1930

17 I HEREBY CERTIFY, That I attended deceased from MAR 3 - 1930, 19 ..., to APR 3 - 1930, 19 ...,

that I last saw h... alive on APR 3 - 1930, 19 ...,

and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

General Senility and Hypostatic Pneumonia

(duration) X yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 10 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical test

(Signed) Otto Duker, M. D.

Apr. 7, 1930 (Address) 928 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Taber Church Cemetery Hickory Harford Co. Md.

DATE OF BURIAL Apr. 6, 1930

20 UNDERTAKER Henry Koch Sons, Inc.

ADDRESS 1301 E Eager St

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

KUREK

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55786 ✓ E 55786

31

CERTIFICATE OF DEATH

REGISTERED NO. E 55786

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 Bank st- ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanislaw Kurek.

(a) RESIDENCE NO. 2123 Bank st- ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	married.

5a If married, widowed, or divorced HUSBAND of ~~[illegible]~~ Michalena Kurek

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER Casmir Kurek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) poland,

12 MAIDEN NAME OF MOTHER Zozina ~~[illegible]~~ schramm.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) poland.

14 Informant Michalena Kurek

(Address) 2123 Bank st

15 Filed APR 4 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 4 30

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to April 4, 1930, that I last saw him alive on April 4 1930 and that death occurred, on the date stated above, at 1Y45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pul. Edema (acute) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Max J. Ziegler, M. D.

4/4, 1930. (Address) 1901 E. Baltic.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	April 7 1930
20 UNDERTAKER	ADDRESS
Geo. A. Weber	705 S. Ann st.

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

Elizabeth R. Monahan ✓

E 55787 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 55787

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 E. Chase St. 10-14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth R. Monahan

(a) RESIDENCE NO. 807 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 11, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Monahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Annie Buckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Annie Monahan

(Address) 807 E. Chase St.

Filed 4 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/30

17 I HEREBY CERTIFY, That I attended deceased from ....., 1923, to 4/2, 1930,

that I last saw h[illegible] alive on 4/2, 1930,

and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 10 Probably yrs. mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) [illegible] M. D.

4/3, 1930 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: April 5 1930

UNDERTAKER: Pila Wiedefeld — ADDRESS: 914 Greenmount Ave

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55788

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55788

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. 23-31 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hughes (Washington)

(a) RESIDENCE NO. 935 Sharp st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hughes

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(h) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 ..... C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to March 31, 1930, that I last saw him alive on March 31, 1930, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Glennee Jr. M. D.

3-31-1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemty

DATE OF BURIAL 4/5 1930

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1394 W Lanvale St

FILED 1930

See instructions on back of certificates. THIS IS very important

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

55789

E 55789

CERTIFICATE OF DEATH

32 E 55789

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hosp. ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Voskel

(a) RESIDENCE NO. Charles 7pt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 9 mos. 1 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 29, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 067

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Voskel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wallner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant August Voskel
(Address) Col. Hgts. - Gay St.

15 Filed ....., 19 .....
APR 4 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3-1930

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1930, to April 3, 1930, that I last saw her alive on April 3, 1930 and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Surgical Pathology & Bacteriology

(Signed) Nicholas Lamporard, M. D.

4/5, 1930 (Address) Union Mem Hospital

*State the Disease Causing Death, or in deaths from Violence state (1) Means and Nature of Injury, and (2) whether Suicidal, or Homicidal. (See reverse side for additional space

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE Apr

20 UNDERTAKER Louis Neuman

AD

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55790

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55790

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH Baltimore City Hospitals 26-27

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bombarlis or Bombino

(a) RESIDENCE NO. none ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant ..... (Address) Records of Baltimore City Hospitals

15 Filed ..... 19 ..... Registrar

4540

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-30

17 I HEREBY CERTIFY, That I attended deceased from 2-14-28, 19..., to 4-1-30, 19..., that I last saw him alive on 4-1-30, 19..., and that death occurred, on the date stated above, at 2:45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvin W McLean, M. D.

4/, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL ... 19

20 UNDERTAKER Commissioner Health

ADDRESS APR 4 - 1930

C. HAMPSON JONES, M.

4 1930

Registrar

HOW to fill out certificates. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 55791

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 16-37 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Beaver

(a) RESIDENCE NO. none ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Dec. 23, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER George Beaver

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germnay

12 MAIDEN NAME OF MOTHER Elizabeth Eyser

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Records of

(Address): Balto. City Hosp.

15 Filed APR 4 - 1930, 19 (6) C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-1-30

17

I HEREBY CERTIFY, That I attended deceased from 11-16-25, 19..., to 4-1-30, 19...,

that I last saw him alive on 4-1-30, 19...,

and that death occurred, on the date stated above, at 9:20 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McLane, M. D.

4-1, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19 APR 4 - 1930

20 UNDERTAKER: M. Commissioner Health

ADDRESS

THIS IS very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55792

E 55792

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp ST. 6-22 WARD)

2-FULL NAME Jno. Gibbons

(a) RESIDENCE NO. 1125 Monroe St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 7th 1927

7 AGE: Years 2 Months 6 Days 27 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John W Gibbons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cumberland Md

12 MAIDEN NAME OF MOTHER Louise Hartman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Hospital Records

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/30 19

17 I HEREBY CERTIFY, That I attended deceased from 4.1.30, 19 ... to 4/3/30, 19 ...

that I last saw him alive on 4/3/30, 19 ...

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 14? ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno A Tompkins M. D.

, 19 (Address) 1211 Fawn Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 4/5 1930

20 UNDERTAKER H. Brining Son Poplar Grove St

ADDRESS 1136

APR 4 1930 C. F. IMPSON JONES, M. D.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55793

CERTIFICATE OF DEATH

REGISTERED NO. E 55793

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) Lawrence & Union (STREET) (WARD) Hospital

2-FULL NAME Louise Smith

(a) RESIDENCE NO. 2610 Colesprings (STREET) (WARD)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 7

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): Aug 18 1924

7 AGE — Years: 5 — Months: 7 — Days: 17 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (City or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James A Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ethel Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant (Address): James A Smith 2610 Cold Springs

15 Filed . 19 Registrar

No. 4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-3-30

17 I HEREBY CERTIFY, That I attended deceased from 3-24-30, 19 . to 4-3-30, 19 .
that I last saw h alive on 4-3-30, 19
and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

1 I.B. Meningitis

(duration) 1 mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Dx

(Signed) B B Hendrix, M. D.

, 19 (Address) 21 Jumpt Bigrd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — DATE OF BURIAL: 4-6 1930

20 UNDERTAKER: Joseph A Lucy — ADDRESS: 409 Marshall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks

Dr Staffly

E 55794 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55794

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 N Calvert ST. 17-19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore A Schmidt

(a) RESIDENCE NO. 1629 N Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Fanny M Schmidt

6 DATE OF BIRTH (month, day, and year): Nov. 29. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 466

(b) General nature of industry, business, or establishment in which employed (or employer): Real Estate

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Lizzie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Fanny Schmidt 1629 N Calvert St.

15 Filed, ... 19 ..... (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 2. 1930

17 I HEREBY CERTIFY, That I attended deceased from apr 1, 1930, to apr 2, 1930, that I last saw him alive on apr 2, 1930, and that death occurred, on the date stated above, at 11.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

unknown

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) same

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) Wm E Stifler, M. D.

4/4. 1930 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 4/5 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 E Fayette

THOMPSON JONES

R4 1930 C. W. SINGER

TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

447 N. Kenwood

E 55795

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55795

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 164 N. Potomac ST. 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Margaret Menninger

(a) RESIDENCE NO. 164 N. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Widow

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND~~ of
or) WIFE of John Menninger

6 DATE OF BIRTH (month, day, and year) Feb. 8, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. ~~Gds~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Mrs. Cathaine Shade
(Address) 164 N. Potomac St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to April 3, 1930,

that I last saw h~~im~~ alive on April 3, 1930,

and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Carditis.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) L. C. Sobital, M. D.

4/4, 1930 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 7 1930
20 UNDERTAKER Meehan & Cook	ADDRESS 1717 St Paul

TION is very important. See instructions on back of certificate.

Vol 3911

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55796

CERTIFICATE OF DEATH

E 55796

1-PLACE OF DEATH

City of Baltimore: (No. 623 Sarah Ann St. 4-25 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthew Smith

(a) RESIDENCE NO. 623 Sarah Ann St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. da. How long in U. S., If of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE — Years: 60 — Months — Days — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Arbury Henry
(Address) Sandy Bottom Rd

15 Filed 4-4-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene Bellert, M. D.

4/4. 1930 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Charleston Md. — DATE OF BURIAL 4/8 1930

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Eaton

Filed ...

Cor. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OCCUPATION in every case. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 55797 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55797

CERTIFICATE OF DEATH. 101-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 N. Monroe ST., 15-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jackson

(a) RESIDENCE NO. 1317 Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ambrose Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Bessie Kelley
(Address) 1317 Monroe St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2-30

17 I HEREBY CERTIFY, That I attended deceased from 3-29-, 1930, to 4-2-, 1930,

that I last saw her alive on 4-1-, 1930,

and that death occurred, on the date stated above, at 3 10 ~~PM~~ AM.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Frank J. Saunders, M. D.

4-3-1930 (Address) 1129 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 4-5 1930

20 UNDERTAKER Thomas E Kelson

ADDRESS 1303 Gaston St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55798 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55798

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (No. 16-23 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Benton

(a) RESIDENCE No. 1317 W. Lafayette ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
22	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John Benton

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Hannah Dobbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records
(Address)

15 Filed 4-7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1929, to April 2, 1930,

that I last saw her alive on April 2, 1930,

and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Jas Thomas M.D. M. D.

4-2, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hamlet, N. C.	4/7 1930

20 UNDERTAKER Thomas E Kelson ADDRESS 1303 Preston St

TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55799 ✓ E 55799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 129

1—PLACE OF DEATH — REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ARD)

2—FULL NAME William Riley

(a) RESIDENCE NO. Lutherville Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postmaster

(b) General nature of industry, business, or establishment in which employed (or employer) +86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Edgar Hastings

(Address) Richmond, Va.

15 Filed APR 4 1930 C. HAMPSON JONES, M. D. Registrar R. C. C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3/1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to April 3, 1930, that I last saw him alive on April 3, 1930 and that death occurred, on the date stated above, at 8:25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History, Phys. Ex. Clin. Signs & Symptoms

(Signed) H. Glenn Speicher M. D.

4/3/1930 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/7 1930

20 UNDERTAKER Henry H. Meyer's Son ADDRESS 805 N. Calvert

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

155 So. Morley St

E 55800 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ E 55800

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 155 S. Morley St

CITY OF BALTIMORE: (No. 70-20 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Müller

(a) RESIDENCE NO. 155 S. Morley St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Muller

6 DATE OF BIRTH (month, day, and year) Feb 2-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	2	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Ebert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Schardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Muller

(Address) 155 S. Morley St

15 Filed APR 4 - 1930 19 By C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1930, to Apr 3, 1930,

that I last saw her alive on Apr 3, 1930

and that death occurred, on the date stated above, at 2.15 P m

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Fred T Kyper, M. D.

4/4/30 (Address) 3321 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gettysburg — DATE OF BURIAL 4/7/30

20 UNDERTAKER Harry V. Wisner — ADDRESS 401 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

(Benhoff)

E 55801

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. ..... ST. 4-7 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Benhoff

(a) RESIDENCE NO. 418 Walesh Road ST., ... WARD Overlea Md

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	7	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Adam A. Benhoff

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Edna Yates

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Adam A. Benhoff.
(Address) 418 Walesh Road

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/30

17 I HEREBY CERTIFY, That I attended deceased from 3/31/30, 19..., to 4/4/30, 19..., that I last saw him alive on 4/4/30, 19..., and that death occurred, on the date stated above, at 1.35 A. M. m.

The CAUSE OF DEATH* was as follows:

Septic Meningitis (Streptococcus Hemolyticus)

(duration) ..... yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute Otitis Media

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) David Turner M. D.

4/4/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Park Wood Cemetery	(April) 19-30
20 UNDERTAKER	ADDRESS
Mary M. Winfield	501 E 22nd

TION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M.

Spec.—1-10-21—M&T—1500 Blks.

(Christine E. Watkins) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55802 E 55802

CERTIFICATE OF DEATH. X 47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 25-72 WARD)

2-FULL NAME Mrs. C. E. Watkins

(a) RESIDENCE NO. Lennox Hotel St. Louis Mo. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Pierre Watkins

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kansas

PARENTS

10 NAME OF FATHER Roderick J. Maclennan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Susan McCan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ottumwa Ia.

14 Informant Pierre Watkins (Address) St Louis Mo

15 Filed 4-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4-1930

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1930, to 4-4, 1930, that I last saw h alive on 4-4, 1930, and that death occurred, on the date stated above, at 5-50 A.m.

The CAUSE OF DEATH* was as follows:

Radical operation for cancer of breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3-27-30

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geauge Brewer, M. D.

April 4, 1930 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kansas City Mo.	April 5th 30
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55803 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55803

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (NO. 36-27 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Swift

(a) RESIDENCE NO. 407 S. Dean st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Weber Swift

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Newberger

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Spring

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed 4-4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20 1930, to Apr. 2 1930,

that I last saw her alive on Apr. 2 1930,

and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos Shannon M. D.

4-3, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 4/5/1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul st

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55804

CERTIFICATE OF DEATH

179 E 55804

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2716 Edmondson Ave ST. 16-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine A. Lee

(a) RESIDENCE NO. 2716 Edmondson Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	widowed

a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Benjamin F. Lee

6 DATE OF BIRTH (month, day, and year) Oct 10-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary Co. Maryland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant. Miss Nellie Lee

(Address) 2716 Edmondson Ave

15 Filed C. HAMPSON JONES, M. D. 19 Registrar

R. 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3-1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 28, 1929, to Apr 3-, 1930

that I last saw h alive on Apr 2-, 1930

and (that death occurred, on the date stated above, at 11 40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at(place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What (est confirmed diagnosis? Physical Examination

(Signed) Paul Brom, M. D.

Apr. 3 1930 (Address) 1663 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	4/5 1930
20 UNDERTAKER	ADDRESS
Wilbur H Sherwood	4130 Edmondson Ave

IF DEATH in plain terms, so that it may be properly classified. EARE statement of OCCUPATION important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55805

CERTIFICATE OF DEATH.

X 101-001 ✓

E 55805

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hospital 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas C Cooney

(a) RESIDENCE NO. 425 E st Spruce Pl. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 9 1928

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	1	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Lawrence C Cooney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Eleanor Sullivan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Oxford Md

14 Informant Mr Lawrence C Cooney

(Address) 425 E st Spruce st

15 Filed 4-1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Autopsy at Hopkins Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. Hollis Calvert, M. D.

(Coroner)

3/4/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bachman Cemetery Date of Burial April 5 1929

20 UNDERTAKER John F Denny ADDRESS 715 Light St

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55806 — 188-001 V — E 55806

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp St. 18-26 Ward)

2-FULL NAME Jacob H Stewart

(a) RESIDENCE NO. 1209 N. Franklin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertha Stewart

6 DATE OF BIRTH (month, day, and year): May 15-1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	47	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lab
(b) General nature of industry, business, or establishment in which employed (or employer): Sterden
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Hann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lottie Gross (Address) 1428 Ashland Ave

15 Filed ... 19... Registrar C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Track in Which he was a pedestrian struck by W B & A Train

CONTRIBUTORY (Secondary): Fract Skull (duration yrs. mos. ds.)

(duration yrs. mos. ds.)

18 Where was disease contracted if not at place of death? Scott & Orkand

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. H. Hann, M. D.

4/4 1930 (Address) 2939 W. Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-5 1930
20 UNDERTAKER	ADDRESS
Jas. Jno. Skinner	1610 E. Madison St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R4-1930

Spec—12-23-21—E.B.R.S.—400 Bks.

E 55807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 3 E 55807

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 Jackson St., 24-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Cronin

(a) Residence No. 507 Jackson St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married or Divorced (Write the word): Married

3a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Timothy Cronin

6-DATE OF BIRTH (month, day and year): March 8, 1857

If LESS than 1 day, ...hrs. or.....min.?

7-AGE: 73 yrs. 0 mos. 26 ds.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: James Gordon

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Curran

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14- (Informant) Timothy Cronin

(Address) 507 Jackson St.

15- Filed 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 3-30

17. I HEREBY CERTIFY, That I attended deceased from March 25 1930 to April 3 1930.

that I last saw h[illegible] alive on April 3 1930.

and that death occurred, on the date stated above, at 5.45 A. M.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Gall Stones.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Schenuit M. D.

, 19 (Address) 1337 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery DATE OF BURIAL, April 7, 1930

20-UNDERTAKER: Margaret D. Flynn ADDRESS 1422 Light St.

C. HAMPSON JONES, M. D.

APR 4 1930

instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55808

CERTIFICATE OF DEATH

E 55808

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital St. 20-71 (Ward)

2-FULL NAME Paul D. Leonard.

(a) RESIDENCE NO. 319 Lyndhurst St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced: (write the word) Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Cora Newark Leonard

6 DATE OF BIRTH (month, day, and year) Aug 8 1851

7 AGE: Years 78 Months 7 Days 26 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Inspector
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER John C. Leonard.

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Lula C. Donnelly.

13 BIRTHPLACE OF MOTHER (city or town) N. Y.
(State or country)

14 Informant Mrs. Cora Leonard
(Address) 319 Lyndhurst St.

15 Filed ... 19... Registrar. C. HAMPSON JONES, M. D.

4 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 - 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Poisoning
Bromal

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. C. Guyer M. D.

19 (Address) 23 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

21 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	4-5-30
20 UNDERTAKER Morgan & Millard	ADDRESS 142 W. Lex

How should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

55809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

55809

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 518 W Preston St. Ward 14-26)

2-FULL NAME Julia A Tolliver

(a) RESIDENCE NO. 518 W Preston St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John H.

6 DATE OF BIRTH (month, day, and year) ? 1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Raymond Tolliver
(Address) 518 E Preston St

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Feb 3rd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an _____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Wheeler M. D.

(Address) Bronx

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alton, Pa.	2/4/1930
20 UNDERTAKER	ADDRESS
Mrs. Geo. H. Holland	16 S Dug King

Must should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55810

REGISTERED NO. 188-001 E 55810

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 916 N. Carollton St. 16-23 Ward)

2-FULL NAME Peter Baines

(a) RESIDENCE NO. 916 Carollton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Mattie

6 DATE OF BIRTH (month, day, and year) ? 1895

7 AGE	Years	Months	Days	If less than 1 day: hrs. or min.
	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) S. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Dora Baines
(Address) 916 N. Carollton

15 [illegible] 6. HAMPSON JONES, M. D. Registrar
R 4 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Struck by a train while an occupant of an auto truck

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Skull

Crushed Chest (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Scott & Osborne

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. J. Faure, M. D.

4/3, 1930 (Address) 3939 W. Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 4/4/30

20 UNDERTAKER: Jno. Geo. H. Holland — ADDRESS: 1628 Druid Hill Ave

Filed Apr 4

Cor.—10-10-29—A Co.—100 Bks. Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 55811

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 18 ✓ E 55811

1-PLACE OF DEATH

City of Baltimore (No.) Retail Mfg. Foot of Chester (St.) 1-4 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph L Everett

(a) RESIDENCE (No.) Chestertown Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2-1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	8	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Marine Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Everett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Johanna Blackstone

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Joseph Everett
(Address) Chestertown Md

15 Filed , 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acc. Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What confirmed diagnosis? History Apr 4

(Signed) Geo Clinton Blades M. D.

(Address) 143 6 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	4/5/30

20 UNDERTAKER Harry A Wilkes

ADDRESS Edmonds

Information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5-1930 C. Flanagan Jones M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55812

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55812

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1835 Rutland Ave ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Gehring

(a) RESIDENCE NO. 1835 Rutland Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Gehring

6 DATE OF BIRTH (month, day, and year) 11-10-1857

7 AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
72	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Hartlove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimd.

12 MAIDEN NAME OF MOTHER Mary J. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md.

14 Informant Geo. J. Gehring

(Address) 1835 Rutland Ave.

15 Filed ... 5-1930 ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929 to April 2 1930, that I last saw her alive on March 25th 1930 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (Ves)

(duration) 1 yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Emma L. Pearson M. D.

4. 3. 1930 (Address) 5, 4 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	4/5/30
20 UNDERTAKER Mary T. Ruth E. L. G.	ADDRESS 1755 Harford

Important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

E 55813

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55813

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hosp St. 15-66 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank M Wilcoxon

(a) RESIDENCE NO. 2108 Mt Holly St ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M. | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Addie C Wilcoxon

6 DATE OF BIRTH (month, day, and year) Nov 21 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	14 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Andrew Wilcoxon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Annie Gelgendamer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant (Address) Joseph Reed

15 Filed 5-1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/30 19

17 I HEREBY CERTIFY, That I attended deceased from 3.30.30 to 4.4.30 19

that I last saw h alive on 4.4.30 19

and that death occurred, on the date stated above, at 4 55 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Hypertension

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Leo A Tumpkin M. D.

19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Apr 7 1930
20 UNDERTAKER	ADDRESS
Wm J Tickner & Son	Mt Pleasant

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55814

HEALTH DEPARTMENT—CITY OF BALTIMORE

61-E 55814

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Hospital for Women of Md. Lafayette Ave & Johns St. WARD)

2—FULL NAME Anne Buffington

(a) RESIDENCE NO. Hosp. for Women of Md. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/20/30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Frederick Buffington

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Windsor, Md.

12 MAIDEN NAME OF MOTHER Ellen Watsons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant John F. Buffington

(Address) 3610 Yolande Road

15 Filed ....., 19 ..... Registrar

5-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1930 to April 3, 1930

that I last saw h.. alive on April 3, 1930

and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH* was as follows:

Prematurity

Bronchopneumonia

Prematurity (duration) life yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 4 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What lesions confirmed diagnosis?

(Signed) Chas. G. Applegarth, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL Apr 5 1930

20 UNDERTAKER Wm J. Tickner & Sons

ADDRESS N & Pa

Important. See instructions on back of certificate.

C. THOMPSON JONES, M.

Spec.—1-12-23—M&T—500 Blks.

Aug-9-
E 55815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 E 55815

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) West Balt. Genl St. 12-21 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A Yost

(a) RESIDENCE NO. 2005 N. Payson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Grace M. Yost

6 DATE OF BIRTH (month, day, and year) Aug 9, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	31	7	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Poultry Dealer
(c) Name of employer: City

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Chas J Yost

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Nellie Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Grace M Yost
(Address) 2005 N Payson

15 Filed [illegible] 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1930

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1930 to April 3, 1930
that I last saw him alive on April 3, 1930
and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix
General Peritonitis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Paralytic Ileus.
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of March 30
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) S. A. Alesse, M. D.
(Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Apr 5 1930

20 UNDERTAKER: W. J. Richardson — ADDRESS: Balto

CAUSE OF DEATH to be plainly stated. Each statement of fact may be proved by different persons, so that if one is absent the other may be produced. Read carefully the instructions on back of certificates. THIS SECTION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 ✓E 55816

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Hammett

(a) RESIDENCE NO. 431 S. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Hammett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Bertha Wiegut

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Bertha A. Hammett
(Address) 431 S Paca Street

15 Filed 5 1930 C. Hampson Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/30

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1930, to April 3, 1930, that I last saw him alive on April 3, 1930 and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Appendicitis, Ruptured

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes (Appendectomy) Date of 3/31/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. Holmes Specht M. D.

19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 6, 1930
20 UNDERTAKER	ADDRESS
John Grebliunckas	431 S Paca St.

important. See instructions on back of certificate.

Spec.—1-12 23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

148 ✓

E 55817

CERTIFICATE OF DEATH.

E 55817

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~1416 Hull~~ West Balto Gen Hosp ST., 2435 WARD)

2-FULL NAME Mrs. Ruby Halfpenny

(a) RESIDENCE NO. 1416 Hull ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Halfpenny

6 DATE OF BIRTH (month, day, and year) Nov 7 1911

7 AGE	Years	Months	Days 26	If LESS than 1 day, hrs. or min.
	18	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrisonburg V.A.

PARENTS

10 NAME OF FATHER Edward Good

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harrisonburg, V.A.

12 MAIDEN NAME OF MOTHER Mamie Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harrisonburg, V.A.

14 Informant Mr Robert Halfpenny (Address) 1416 Hull St.

15 Filed 5-1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 1930, to 4/3, 1930, that I last saw her alive on 4/3, 1930 and that death occurred, on the date stated above, at 1 54 m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 4/2/30

Was there an autopsy? no Extraction

What test confirmed diagnosis? clinical + Labratory

(Signed) S. A. Alessi, M. D.

19 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	April 7 1930
20 UNDERTAKER Chas. L. Gruver	ADDRESS 1330 E Fort Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 55818

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Riggs Av ST., 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mazie Barbee Conney

(a) RESIDENCE NO. 1718 Riggs Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Conney

6 DATE OF BIRTH (month, day, and year) Feb 22-93

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER George Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Venera Trail

(Address) 1718 Riggs Av

15 Filed [illegible] 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 4, 1930, to April 3, 1930

that I last saw h[illegible] alive on April 3, 1930

and that death occurred, on the date stated above, at 5.15 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

about 1 yrs. mos. ds.
(duration)

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. M. Bagott, M. D.

4/8, 1930 (Address) 1536 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	4/6 1930
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—8-16-29—L. F. S.—100 Blks. Michaline Sczerbicki.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55819 100-901 E 55819

CERTIFICATE OF DEATH

REGISTERED NO. 13-52

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary Szczerbicki

(a) RESIDENCE NO. 1113 N. 36th St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Szczerbicki.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Wladislaw Klos.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia Rusinowicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Szczerbicki.

(Address) 1113 N. 36th St. Baltimore, Md.

15 Filed ... 19... Registrar

R.F. - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 4, 1930, that I last saw her alive on April 4, 1930, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Broncho. pneumonia

(duration) ... yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Obesity

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George H. Yeager. M. D.

April 4 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	April 7. 1930.
20 UNDERTAKER W. J. Sadowski.	ADDRESS 2215 Elhanan Av

important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55820

CERTIFICATE OF DEATH.

84 E 55820

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital 7-13 ST., WARD)

2-FULL NAME Helen Lumpkin (LUMPKIN)

(a) RESIDENCE NO. 704 Duncan St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 1 1921

7 AGE. Years: 8 Months: 3 Days: 14 If LESS than 1 day, hrs. or min.: 3

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Robert Lumpkin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Eller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Robert Lumpkin 704 Duncan St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Feb 4 1930

17 I HEREBY CERTIFY, That I attended deceased from 10-18 1929 to 4-4 1930, that I last saw her alive on 4-4 1930, and that death occurred, on the date stated above, at 2 45/60 m.

The CAUSE OF DEATH* was as follows:
Cerebellar Tumor (Rt)

(duration) yrs. 7 mos. ? ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 11-2-30 3-24-30

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) M M Marder M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Feb 7 1930

20 UNDERTAKER: Frank Grach & Son 1916 — ADDRESS: Holland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5 1930 C. HAMPSON JONES, M.D.

NRPO

Spec.—8-16-29—L. F. S.—100 Bks.

E 35383
E 55821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 55821

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Editth Clarke

(a) RESIDENCE NO. 613 N Robinson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	✓	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jesse Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Myrtle Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records
(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4-1930

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to April 4, 1930, that I last saw h is alive on April 4, 1930 and that death occurred, on the date stated above, at 5-45 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 5 weeks

CONTRIBUTORY (Secondary) Congenital Heart Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Benjamin E. Hodges M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL April 7 1930

20 UNDERTAKER Robt J Turner

ADDRESS 1 E Fayette St.

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E55822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 55822

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No.) ST. 16-Wa (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Smith

(a) RESIDENCE NO. 1037 W. Saratoga st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Elijah Smith

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Tasker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1930, to April 3, 1930,

that I last saw her alive on April 3, 1930,

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thomas Jr M. D.

4-4, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 6, 1930
20 UNDERTAKER	ADDRESS 3224
Mrs Katie R. Williams	Schroeder st

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Sewell

E 55823

CERTIFICATE OF DEATH.

E 55823

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1141 Argyle Ave (St.) 17-24 (Ward)

2-FULL NAME Norma Sewell

(a) RESIDENCE. No. 1141 Argyle Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wilson Sewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Selena Chambers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Elvira Chambers
(Address) 1141 Argyle Ave

15 Filed 4-5 1930 C. H. LEMMON JONES M. D. Registrar
Reg. No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-4- 1930, to 4-4 1930, that I last saw her alive on 4-4 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Wm. E. Harris, M. D.

, 19 (Address) 1200 Penn Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 6, 1930
20 UNDERTAKER	ADDRESS 3224
Mrs Kate R. Williams	Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificate.

4-5-1930

Spec.—8-16-29—L. F. S.—100 Blks.

E 55824

E 55824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55824

129

REGISTERED NO. 13-58

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 Lennox ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine I. O'Connor

(a) RESIDENCE NO. 613 Lennox ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 9 mos. 26 ds. How long in U. S., if foreign birth — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Hyde O'Connor

6 DATE OF BIRTH (month, day, and year) June 8, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael A. Canton

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan L. McGraw

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Miss Rosalie M. Canton

(Address) 613 Lennox Street

15 Filed C. HAMPSON JONES, M. D. Registrar

APR 5 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 - 30

17 I HEREBY CERTIFY, That I attended deceased from Mch 28, 1930, to April 3, 1930, that I last saw h alive on April 3, 1930 and that death occurred, on the date stated above, at 0 m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis - Pulm. Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John F Beale, M. D.

(Address) 20 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4/7 1930

20 UNDERTAKER Henry W. Weaver Son

ADDRESS 505 N. Calvert

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55825

CERTIFICATE OF DEATH

101-081 E 55825

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Barkus

(a) RESIDENCE NO. 1238 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year) 2/12/1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Penny Parker

(Address): 1238 Jefferson St

15 Filed ... 19 ... Registrar

C. HAMILTON JONES, M. D.

APR 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-30

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1930, to April 5, 1930, that I last saw h[illegible] alive on April 3, 1930 and that death occurred, on the date stated above, at 10 [illegible] a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 12 da.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. S t Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	April 5 1930
20 UNDERTAKER	ADDRESS
Mrs J. G. Locks	1352 Jefferson St.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55826 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55826

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2651 Maryland Ave. ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Neal

(a) RESIDENCE NO. 2651 Maryland Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Neal

6 DATE OF BIRTH (month, day, and year) June 1, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Neil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Nellie A. Neal

(Address) 2651 Maryland Ave.

15 Filed Apr 5, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1929, to April 4, 1930, that I last saw her alive on April 3, 1930, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Senile Arterio Sclerosis

Chronic interstitial nephritis

over (duration) yrs. 7 mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry E. Aldo M. D.

Apr 5 1930 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Apr. 7, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Mahlon B. Mitchell

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55827

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 55827

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1815 N. Port St. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Baader

(a) RESIDENCE NO. 1815 N. Port ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single, Married, Widowed,~~ or Divorced, ~~(write the word)~~: Widow

6 DATE OF BIRTH (month, day, and year): April 2 1866

7 AGE: Years 64 Months 6 Days 3 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, md

PARENTS

10 NAME OF FATHER: Sergt Biermann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germy

12 MAIDEN NAME OF MOTHER: Nehmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germy

14 Informant: John L. Baader

(Address): 1815 N. Port

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1930

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1928, to April 5, 1930, that I last saw her alive on April 4, 1930, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Cortic Insufficiency
Arterial Hypertension

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Decompensation

(duration) yrs mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical examination

(Signed) Albert Brantley, M. D.

4/5 1930 (Address) 2005 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	Apr 7 1930
20 UNDERTAKER	ADDRESS
Jos Saunders Son	2178 E. Pratt

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55828 E 55828

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Smith Fisher

(a) RESIDENCE NO. Great Geapon St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if foreign birth? ✓ yrs. ✓ mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13-1903

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
26	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): W. Va.

PARENTS

10 NAME OF FATHER: William M. Fisher.

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Anna Boyne.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia.

14 Informant: Mrs. Raymond Dawson.
(Address) 1833 W. Fayette St.

15 Filed ..., 19 ... Registrar

APR 5 - 1930

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4/1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to April 4, 1930; that I last saw him alive on April 4, 1930; and that death occurred, on the date stated above, at 12:15 A.m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/2/30

Was there an autopsy? No.

What test confirmed diagnosis? Pathology Phy & Clin

(Signed) H. Glenn Spotnitz M. D.

4/4/1930 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Tabo Cemetery - W. Va.	April 6 - 1930
20 UNDERTAKER	ADDRESS
Charles J. Schwab	505 N. Monroe St.

Spec.—1-30—M. & T.—250 Bks.

E 55329 HEALTH DEPARTMENT—CITY OF BALTIMORE 101 E 55329

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2953 (Street) Clifton Ave ST. (Ward) 15-67

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara V. Greenfield

(a) RESIDENCE No. 2953 Clifton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. E. Greenfield

6 DATE OF BIRTH (month, day, and year) Dec 6 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68.	3	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Thomas Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D C

12 MAIDEN NAME OF MOTHER Margaret Seaton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D C

14 Informant (Address) Wm. E. Greenfield 2953 Clifton Ave

15 Filed APR 5 - 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 6, 1930, to Apr 4, 1930, that I last saw her alive on Apr 4, 1930, and that death occurred, on the date stated above, at 1.55 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration), yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Dis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest K. Calvert M. D.

1930 (Address) 3006 W North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington DC.	4/6 1930
20 UNDERTAKER P. J. Soffell	ADDRESS 733 S. Fulton Ave

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55830

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55830

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) 14-20 31

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanette Gibson

(a) RESIDENCE NO. 1516 Druid Hill ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Ernest Gibson

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23 22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 010

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James A. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mamie Falcon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1929, to April 3, 1930,
that I last saw her alive on April 3, 1930,
and that death occurred, on the date stated above, at 5.30 p. m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Thrower Jr M.D.

4-4-1930 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Co Millenbeck Wharf Va

DATE OF BURIAL 4/6 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 303 Preston St

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 55831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55831

24-33 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 118 E. Hamburg St. St., Ward

2-FULL NAME William E. Finer.

(a) RESIDENCE NO. 118 E. Hamburg St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of Rule E. Finer.

6 DATE OF BIRTH (month, day, and year) January 31, 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	46	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informan) Rule E. Finer. (wife)
(Address) 1005 William St.

15 Filed APR 5 - 1930 HARRY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardiol insufficiency.
Acute dilatation of the Heart.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Kernhardt, M. D.

4/6, 1930 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alexandria Va. Via Auto

DATE OF BURIAL: April 5 1930

20 UNDERTAKER: John F. Denny

ADDRESS: 7 S. Light St.

BE SURE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55832

CERTIFICATE OF DEATH

74-001 E 55832

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Smith

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Burkhart Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Elij. Naire

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Little Sisters of the Poor
(Address) Preston & Valley

15 APR 6 1936 Filed ....., 19.... HAMPDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 1930, to 4/4, 1930, that I last saw h alive on 4/3 1930 and that death occurred, on the date stated above, at P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Bernard Lucas M. D.

4/5, 1930 (Address) 916 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Reformed Congregation	Apr 7 1930
20 UNDERTAKER	ADDRESS
Rita Wiedefeld	914 Fremont Ave

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55833

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55833

CERTIFICATE OF DEATH.

11-24 101-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 54 W. Biddle ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Hamilton Rawls

(a) RESIDENCE NO. 54 W Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word)
Male	White	Single

5a If ~~married, widowed, or divorced~~ HUSBAND) of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Sept 9th 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER William L Rawls

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Anna Stumpf

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Wm L Rawls.

(Address) 54 W Biddle St

15 Filed 10-1930 19 C. HAMPTON JOYCE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1930

17 I HEREBY CERTIFY, That I attended deceased from March, 1928, to April 5, 1930,

that I last saw him alive on April 5, 1930,

and that death occurred, on the date stated above, at 6 10 A. m.,

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Meningitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. E. + Culture

(Signed) Chas Cerqueda, M. D.

, 19 (Address) 8 E. Edgar St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Thomas Garrison Forest — DATE OF BURIAL: April 7 1930

20 UNDERTAKER: Henry J Weikin & Son Co — ADDRESS: Oxford & Collins St

Spec.—1-30—M. & T.—250 Blks Dr Dr Hoff 2020 N. Charles Mus 0565 9 a.m. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55834 E 55834

CERTIFICATE OF DEATH.

129

REGISTERED NO. 12-50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2923 Guilford Ave ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Dayt Crumpt

(a) RESIDENCE NO. 2923 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND OF~~ (or) WIFE of Williams Crumpt

6 DATE OF BIRTH (month, day, and year) 2/21/1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Jacob Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Rebecca Cromwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Wm Crumpt

(Address) 2923 Guilford Ave

15 Filed ..., 19 ... RMC, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/1930

17 I HEREBY CERTIFY, That I attended deceased from April 1. 1930. to April 4. 1930.

that I last saw her alive on April 4. 1930

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

Chronic Nephritis (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Prudence Hoff, M. D.

4/5. 1930 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 4/7/1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks Dr Geo. D. Young 1834 St Paul St Jan 2657

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55835

CERTIFICATE OF DEATH.

31 E 55835

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1601 Braddish Ave ST. 15-68 WARD)

2-FULL NAME Wilson C. Dubs

(a) RESIDENCE NO. 1601 Braddish Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Emma

6 DATE OF BIRTH (month, day, and year) 9/3/1887

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
42	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer) R.R.

(c) Name of employer Western Md R.R

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Daniel Dubs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Emma Wagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant Emma Dubs (Address) 1601 Braddish Ave

15 Filed APR 6 - 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/30

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to April 4, 1930, that I last saw him alive on April 3, 1930, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows: Tuberculosis of Spine Slight involvement of both Lungs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Geo D Young, M. D.

April 5, 1930 (Address) 1834 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 4/7/1930

UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55836

CERTIFICATE OF DEATH

E 55836

1-PLACE OF DEATH St. Joseph's Hospital. REGISTERED NO. 117

CITY OF BALTIMORE: (No. St Ann. ST. 25-75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Mc Namara

(a) RESIDENCE NO. 3443 Hanover Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of John Mc Namara

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry Faber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Clemmie Raymond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Morton Bowen

(Address) 3443 Hanover St

15 Filed . 19 R Pyle Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 29, .1930. to April 5th .1930,

that I last saw he alive on April 5th .1930,

and that death occurred, on the date stated above, at 1:48 AM m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis

(Duration) yrs mos ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia 3 days (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 31, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. J. Sundheim M. D.

. 19 (Address) 1 W. Mt. Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetary — DATE OF BURIAL: 4/8/ 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HARRISON JONES, M. D.

APR 6 1930

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55837

CERTIFICATE OF DEATH.

E 55837

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 13-57 ST. 90 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Steinmeier

(a) RESIDENCE NO. 4226 Falls Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Steinmeier

6 DATE OF BIRTH (month, day, and year) ~~Sept~~ 16 1857 - 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65 - 72	72	11	17 - 18	

8 OCCUPATION OF DECEASED Retired ~~Unknown~~

(a) Trade, profession or particular kind of work ~~Unknown~~ O.K.

(b) General nature of industry, business, or establishment in which employed (or employer) Meat Market

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Steinmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of (Address) Balto. City Hosp.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-3-30

17 I HEREBY CERTIFY, That I attended deceased from 6-10-29, 19..., to 4-3-30, 19..., that I last saw him alive on 4-3-30, 19..., and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) over 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Senile Dementia

(duration) over 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren W. McLean M. D.

4-4, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 7 1930

20 UNDERTAKER W. M. Loudon

ADDRESS 2237 N. Monte

APR 8 1930 HAMILTON JONES, M. D.

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55838

CERTIFICATE OF DEATH.

4 E 55838

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Poplar Grove St.) (16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Erika Merritt

(a) RESIDENCE NO. 1417 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 7, 64

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John P Merritt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Heritage

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England.

14 Informant Miss Bessie Grant
(Address) 1417 Poplar Grove

15 Filed APR 6 - 1930 By C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 30

17 I HEREBY CERTIFY, That I attended deceased from April, 1930, to April 5, 1930,

that I last saw her alive on March 4, 1930,

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. mos da.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo Pfanning M. D.

6 1930 (Address) 1834 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	April 1930
20 UNDERTAKER	ADDRESS
W M Routson	2238 W Balto

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55832 — 90 ✓ — E 55839

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1743 E. Oliver ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry C. Frost

(a) RESIDENCE NO. 1743 E. Oliver ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Conrad Frost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER C. Hilzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lydia Frost

(Address) 1743 E. Oliver St.

15 Filed ....., 19.... Registrar

DEC 6 - 1930

H. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4-1930

17 I HEREBY CERTIFY, That I attended deceased from March 28th, 1930, to April 4th, 1930, that I last saw h.im alive on April 4th, 1930 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Harris Goldman M. D.

4/6/ 1930 (Address) 1816 W North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodmansee Cem. April 7	1930
20 UNDERTAKER	ADDRESS
John C. Miller	2435 E. Oliver

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55840

CERTIFICATE OF DEATH.

101-001 E 55840

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST. 27-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Slembecker

(a) RESIDENCE NO. 4007 Northern Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or ~~Divorced~~. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Augusta Slembecker

6 DATE OF BIRTH (month, day, and year): July 19-1885

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
45	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Secretary

(b) General nature of industry, business, or establishment in which employed (or employer): Brokerage Co

(c) Name of employer: Dennis & Co-Inc

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Gotleib-Slembecker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Carolina Danna

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Augusta Slembecker 4007 Northern Parkway Wife

15 Filed APR 8 - 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1930, to 4-4, 1930, that I last saw him alive on 4-4, 1930, and that death occurred, on the date stated above, at 4.20 Am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary): Cardiac Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs.

(Signed) W. B. Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem't	April 7 1930
UNDERTAKER	ADDRESS
Edward E Lilly	3318 Glenmore Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55841

31 Nov Amended E 55841

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 S. Ellwood Ave. BK. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wiley

(a) RESIDENCE NO. 29 S. Ellwood Ave ST. 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank G. Wiley

6 DATE OF BIRTH (month, day, and year) March 11th 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Loeffler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margarite Loeffler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Frank G. Wiley
(Address) 29 S. Ellwood ave

15 Filed ..... 19 ..... HARRY JONES, M. D. Registrar

RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12, 1930, to April 3, 1930, that I last saw her alive on April 1, 1930, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. B. Bowmaster, M. D.

4-3 1930 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	Apr. 5th 1930
20 UNDERTAKER Lilly & Julian Inc.	ADDRESS 403 S. Wolfe St

PAID-10.00

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55842 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 55842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO.

CITY OF BALTIMORE: (NO. 26-31 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Foertschbeck

(a) RESIDENCE NO. 3609 Foster ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth Unknown mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57 56				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 062

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jos. Foertschbeck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julian ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address)

15 Filed APR 6 1930 C. HAMPSON JONES, M. D. By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1928, to April 3, 1930, that I last saw him alive on April 3, 1930, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos Glennon Jr M. D.

4-4, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery — DATE OF BURIAL April 7 1930

20 UNDERTAKER Lilly + Julian Inc. — ADDRESS 403 S. Wolfe St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55843

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 55843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 Jefferson ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis R. Holmes

(a) RESIDENCE NO. 1226 Jefferson ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arminta Holmes

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer O+O

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Stanley & Curtis Bay

9 BIRTHPLACE (city or town) Hortstown Va
(State or country)

PARENTS

10 NAME OF FATHER Lewis Holmes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Annie Towning

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Arminta Holmes
(Address) 1226 Jefferson St

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3-30

17 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1930, to April 3, 1930, that I last saw h live on April 3, 1930, and that death occurred, on the date stated above, at 10^05 m.

The CAUSE OF DEATH* was as follows:

Acute Croupous Pneumonia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) S. B. Seely, M. D.

4-3-1930 (Address) 508 Somerset St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL 4-6 1930

20 UNDERTAKER Byron & Wright

ADDRESS 218 McElderry St

TION is very important See instructions on back of certificates.

Spec.—1-20—M. & T.—250 Blks

E 55844

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55844

CERTIFICATE OF DEATH.

REGISTERED NO. 86

1. PLACE OF DEATH

CITY OF BALTIMORE, (No. 1834 Edmondson ave ST., 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Antonette V. King

(a) RESIDENCE NO. 1834 Edmondson ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 3, 1911

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
18	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attendant

(b) General nature of industry, business, or establishment in which employed (or employer) School.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Anthony J. King

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Victoria Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Victoria King

(Address) 1834 Edmondson ave

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1930 to April 3, 1930

that I last saw her alive on April 3, 1930

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus viridans,
Subacute bacterial endocarditis.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cardiac dilitatinn.

(duration) yrs. mos. ds. about a week.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture and examination of patient.

(Signed) [illegible] M. D.

(Address) 3429 Chestnut Ave 4/5, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 7 1930

UNDERTAKER John A. Moran — ADDRESS 3000 E. Balto St.

APR 8 1930

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55845

129 E 55845

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 9-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie J. Fisher

(a) RESIDENCE NO. 1730 Gorsuch Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Robert E. Fisher

6 DATE OF BIRTH (month, day, and year) July 11/1877

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
52	8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Henry J. Fuhrman
(Address) R.F.D. No 6 Towson, Md.

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (Chr)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical History

(Signed) Jos. M. Walker, M. D.

4/5/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	April 7 1930
20 UNDERTAKER	ADDRESS
Horace K. Burgee	3031 Fait

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-29—3&T—500 Blks.

E 55846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55846

REGISTERED NO. 28-64

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 4314 Wentworth Rd. (WARD) 28

2-FULL NAME Anice Elvira Kent.

(a) RESIDENCE NO. Milton Pa. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	W.	Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Isaac J. Kent.

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	74	1	19	18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Binghampton N. Y.

PARENTS

10 NAME OF FATHER John Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Jane C. Birch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) J. M. Lindner 4314 Wentworth Rd.

15 Filed 1930 C. HAMPSON PHILLIPS M.D. Registrar

PRE-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 3 1930, to apr 5 1930, that I last saw her alive on apr 5 1930 and that death occurred, on the date stated above, at 10.25 a. m.

The CAUSE OF DEATH* was as follows:

Labyrinthitis following Otitis Media.

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Bronchitis followed by Otitis Media (duration) yrs. mos. 33 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Dept. of Health to Mar 11

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Edward H. Ruth, M. D.

4/5 1930 Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Milton, Pa. DATE OF BURIAL: April 7 1930.

20 UNDERTAKER: Horace F. Burgee ADDRESS: 3631 Falls Rd.

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—12-8-25—A Co.—700 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55847

CERTIFICATE OF DEATH.

161-001 E 55847

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1410 E. Chase St. Ward) 16-13

2-FULL NAME Evelyn Hughes

(a) RESIDENCE NO. 1410 E Chase St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. 2 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Sigle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 4-4-30

7 AGE — Years | Months | Days: 2 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town): Baltimore md

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) —

12 MAIDEN NAME OF MOTHER Theresa Hughes

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant: Evelyn Hughes

(Address) 1410 E Chase

15 Date APR 6 - 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 4-4-30

17 I HEREBY CERTIFY, That I attended deceased from Birth 4-4-30, 19, to 4-6-30, 19,

that I last saw her alive on 4-6-30, 19,

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unable to take food:

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Ernest C. Milton, M. D.

, 19 (Address) 2029 Pa. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: 4/6/1930

20 UNDERTAKER: Mrs. Leo. H. Hellan — ADDRESS: 1637 Druid Hill Ave

very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55848 ✓ E 55848

CERTIFICATE OF DEATH.

#7

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. ST. 22-30 (WARD)

2-FULL NAME Mamie Pitcher

(a) RESIDENCE NO. 614 N. Hanover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Pitcher

6 DATE OF BIRTH (month, day, and year) Oct 16, 1872

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
57	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of Industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

037

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Mattingly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Virginia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4-30

17 I HEREBY CERTIFY, That I attended deceased from 3-19, 1930, to 4-4, 1930, that I last saw h-e alive on 4-4, 1930, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma breast - bilateral
Metastasis to lungs

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Broncho pneumonia
(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin M. D.

4-5, 1930 (Address) Balto City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL April 7, 1930

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1432 Light

APR 6 1930 C. HAMPSON JONES, M.D.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55849 — 111-001 — E 55849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (ST.) 4-47 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas F Flannery

(a) RESIDENCE NO. 1027 (ST.) York Road (WARD)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clothilde Flannery

6 DATE OF BIRTH (month, day, and year) about 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	63	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Bridge Building
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Flannery

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Ireland

12 MAIDEN NAME OF MOTHER Mary Gleason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Ireland

14 Informant Dr. F. J. Flannery (brother)
(Address) 1027 York Road

Filed APR 6 1930 C. HAMPTON JONES, M. D. Registrar.

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/30 19

17 I HEREBY CERTIFY, That I attended deceased from 3/31/30 . 19 . to 4/5/30 . 19 .
that I last saw h[illegible] alive on 4/5/30 . 19 ,
and that death occurred, on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH* was as follows:
perforated gastric ulcer

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) myocardial degeneration
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/2/30

Was there an autopsy? Yes Report on hand

What test confirmed diagnosis?

(Signed) W B Hendrix M. D.

4/7, 1930 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: April 7, 1930

20 UNDERTAKER: Stewart & Mowen Company — ADDRESS: 108 W. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 55850

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55850

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. ~~1010 St. Paul St.~~ Mercy Hospital ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry R. Labouisse

(Residence in Baltimore: No. Belvedere Hotel St.: yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	married

6-DATE OF BIRTH. November 8, 1867 (Month), (Day), 1 (Year)

7-AGE. 62 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer): cotton broker

9-BIRTHPLACE, (State or Country). New York City

PARENTS.

10-NAME OF FATHER. John W. Labouisse

11-BIRTHPLACE OF FATHER (State or Country). New Orleans, La.

12-MAIDEN NAME OF MOTHER. Katherine Richardson

13-BIRTHPLACE OF MOTHER (State or Country). New Orleans, La.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John W. Labouisse
2434 Cherokee Road
(Address) Charlotte, N. C.

15-
Filed APR 6 1930, 191... R.W.K. Registrar.

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 5, 1930
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Cutting throat with razor

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Culley Coroner M. D.
(Coroner)

Apr. 6 1930 (Address) 1639 E. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? New Orleans La.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Orleans, La.	Apr. 7, 1930

20-UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw pl

Walton B. Mitchell

CAUSE OF DEATH must be plainly written, and may be properly classified. Care taken in this particular is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55851

CERTIFICATE OF DEATH.

31 E 55851

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2924 Monticello ST. 4-46 WARD)

2-FULL NAME John Richard McComas

(a) RESIDENCE NO. 2924 Monticello ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~the wife of~~ Mary Gaskell McComas

6 DATE OF BIRTH (month, day, and year): Dec. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General painter, plasterer, gardener

(b) General nature of industry, business, or establishment in which employed (or employer): Lazy lunch and get.

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: John McComas.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs. Esther Payne (Address) 114 E. 30 St. City.

15 Filed APR 6 - 1930 19 31 C. HAMILTON JONES, M. D. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 3, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 10, 1930, to Apr. 1, 1930, that I last saw h/~~m~~ alive on Apr. 1, 1930, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary tuberculosis.

Mycocarditis.

Not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular fibrilation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) William A. Lighty, M. D.

19 (Address) 2624 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Co.

UNDERTAKER: J. A. Moran

DATE OF BURIAL: 4/7/ 1930

ADDRESS 3000 E Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 55852

E 55852

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2508 E. Preston ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Pedone

(a) RESIDENCE NO. 2508 E. Preston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Salvatore

6 DATE OF BIRTH (month, day, and year) Jan 1- 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Matteo Pinto

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Anna Flanigan
(Address) 1508 E Preston St.

15 Filed ....., 19.. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 - 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1930, to Apr 4, 1930

that I last saw her alive on Apr 3, 1930

and that death occurred, on the date stated above, at 5 32 a m.

The CAUSE OF DEATH* was as follows:

Aortic Sclerosis, Hypertension
Diabetes Mellitus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 10 hrs.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hematuria + Sphig.

(Signed) Thos. A. Scarano, M. D.

4-7, 1930 (Address) 2878 Halford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	4/7/ 1930
20 UNDERTAKER J. G. Moran	ADDRESS 3000 E Baltimore

Important. See instructions on back of certificate.

E55853 E55853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hospital — REGISTERED NO. 166

CITY OF BALTIMORE: (No. ... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Otto Ehrlich

(a) RESIDENCE NO. 2813 W. Mulberry ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7y yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Ehrlich.

6 DATE OF BIRTH (month, day, and year) 9/16/1897

7 AGE Years	Months	Days	If LESS than 1 day ... hrs or ... min
32	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) United Railways

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Walter Ehrlich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Doppe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Margaret Ehrlich (Address) 2813 W. Mulberry

15 Filed ... 19... HAMPSON JONES, M. D. Registrar

PRG-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1930

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1930, to April 3, 1930, that I last saw h[illegible] alive on April 3, 1930 and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows: (Suicide)

Bichloride of mercury poisoning

(duration) ... yrs. ... mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

Where did disease contracted if not at place of death? At home

Did operation precede death? No Date of —

Was there an autopsy? Yes

What diagnosis confirmed? Clinical & autopsy.

(Signed) J. V. Castagna, M. D.

19 (Address) W. Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 4/7/30 19

20 UNDERTAKER Tracy T. Ruddy — ADDRESS 1730 Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55854 ✓ E 55854

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William C Johnson

(a) RESIDENCE NO. Milford Del ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 15

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country): Del

PARENTS

10 NAME OF FATHER: Wm B.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Del

12 MAIDEN NAME OF MOTHER: Mary J. Stayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 6 1930, 19 CLAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April-5-1930

17 I HEREBY CERTIFY, That I attended deceased from March 19 1930 to April 5, 1930, that I last saw h.. alive on April 5, 1930 and that death occurred, on the date stated above, at 8 06 P. m.

The CAUSE OF DEATH* was as follows:

Spinal cord tumor-
Malignant

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Rad. o/o - Meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-25-30

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Chas Binney, M. D.

4/6, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Milford, Del.

DATE OF BURIAL: 4-6-1930

20 UNDERTAKER: Jack Lewis,

ADDRESS: 1739 Eb...

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55855

CERTIFICATE OF DEATH.

90 E 55855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3534 Virginia Ave ST. 15-58 WARD)

2-FULL NAME Susan Yengling

(a) RESIDENCE NO. 3534 Virginia Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Yengling

6 DATE OF BIRTH (month, day, and year) Aug 15 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lancaster Co Penna.

PARENTS

10 NAME OF FATHER Geo. Kendig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Charles F Gentz (Address) 3534 Virginia Ave.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 1930, to April 6, 1930, that I last saw h[illegible] alive on April 5th, 1930, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Howard Hanna M. D.

46. 1930 (Address) 3002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ederheim Lancaster Penna. DATE OF BURIAL April 10th 1930

20 UNDERTAKER Wm J. Tickner & Sons ADDRESS Nor Pa.

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 55856 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55856

CERTIFICATE OF DEATH.

161-901

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 E. Preston St.) (13 WARD)

2-FULL NAME Baby girl Ward.

(a) RESIDENCE NO. 1713 E. Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) April 6. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1 hour			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John. Ward.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Madeline Maloney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) John Ward. 1713 Preston St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/6/30 , 19 , to 4/6/30 , 19 , that I last saw h[illegible] alive on 4/6/30 , 19 , and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) 1 hour yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible] M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Apr 8. 1930
20 UNDERTAKER	ADDRESS
Rita Wiedefeld	14 Greenmt Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 55857

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 55857

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2615 Fleet St. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Norbert Kwiatkowski

(a) RESIDENCE NO. 2615 Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joe Kwiatkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Francis Slawinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Joe Kwiatkowski

(Address) 2615 Fleet St.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

R 7 -1930

RMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4-30

17 I HEREBY CERTIFY, That I attended deceased from April 1 1930, to April 4, 1930, that I last saw h in alive on April 4, 1930 and that death occurred, on the date stated above, at 12 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John V. Szurbicki, M. D.

19 (Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary April 7	1930 19

20 UNDERTAKER W. H. Ozazewski ADDRESS 1930 Eastern Ave

IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

55858 | 1284 | E 55858

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 Pierce St. 17-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Wilkins

(a) RESIDENCE NO. 601 Pierce St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs 7 mos 21 ds. How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 14, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	6 7	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Wilkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Viola Holly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Henry Holly (Address) 601 Pierce St

15 Filed . 19 Registrar

PR 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar . 1930 . to April 4 . 1930 . that I last saw h (alive on April 3 . 1930 . and that death occurred, on the date stated above, at 2.30 A.m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) — yrs 2 mos — ds.

CONTRIBUTORY (Secondary) now (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelleman M. D.

. 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL Apr 7 1930

20 UNDERTAKER E. J. Ingram & Bro ADDRESS 1437 Pa Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55859

CERTIFICATE OF DEATH.

129

E 55859

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Harlem Ave. ST. 16-26 WARD)

2-FULL NAME Mary Elizabeth Harvey

(a) RESIDENCE NO. 1113 Harlem Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Widowed

5a If married, widowed, or divorced (or) WIFE of Amos Harvey

6 DATE OF BIRTH (month, day, and year) June 1, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Long Green Md.

PARENTS

10 NAME OF FATHER Samuel Hissey?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Hines?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Cordelia H. Keys

(Address) 1113 Harlem Ave

15 Filed . 19 . Registrar RPK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1 . 1930 . to Apr. 5 . 1930 , that I last saw her alive on Apr. 5 . 1930 , and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis, Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Uremia, Acute Dilatation of Heart (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Ex.

(Signed) Wm. LeRoy Perry , M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Long Green Cemetery DATE OF BURIAL Apr 8 1930

20 UNDERTAKER Virginia A. Brooks ADDRESS Balto. Co. Md.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—160 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 E 55860

55860

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Medical Arts Building St. 12-50 Ward)

2-FULL NAME Walter M. Garrett

(a) RESIDENCE NO. 212 W Lorraine St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Garrett

6 DATE OF BIRTH (month, day, and year) Jan 1892

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	38	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Superintendent
(b) General nature of industry, business, or establishment in which employed (or employer) Dairy
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER W. T. Garrett

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER R. Wingate

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Elsie Garrett
(Address) 212 W Lorraine

15 Filed Oct 10 1930 CHAMPE FOSTER, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (Coronary Thrombosis)
Sudden - (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Fahey, M. D.

Oct 6 1930 (Address) 1639 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Oct 10
20 UNDERTAKER	ADDRESS
Boyle & Foley	Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—3-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55861

CERTIFICATE OF DEATH

E 55861

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Wyanoke Ave. WARD) 47

2—FULL NAME Mary M. Rennie

(a) RESIDENCE NO. 616 Wyanoke Ave. WARD 63

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced RUSBAND of (or) WIFE of William Rennie

6 DATE OF BIRTH (month, day, and year) May 30. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	78	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Scotland

PARENTS

10 NAME OF FATHER James J. Milroy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Pearson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Mrs. Frank S. Brady.

(Address) 616 Wyanoke Ave

15 Filed ____ 19__ C. HAMPSON JONES, M. D. Registrar

By: RRH.

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 30.

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1930, to Apr 6, 1930, that I last saw h-- alive on Apr 5, 1930, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis

(duration) yrs 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W Donaldson, M. D.

(Address) 1714 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: Apr 8 1930.

20 UNDERTAKER: Mrs. John R. Penfold & Son ADDRESS: 631 W. Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55862

CERTIFICATE OF DEATH

E 55862

REGISTERED NO. 47

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4403 Belvieu Ave (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence L Seim

(a) RESIDENCE NO. 4403 Belvieu Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 8 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert H Seim

6 DATE OF BIRTH (month, day, and year): July 26 1887

7 AGE: Years 42 | Months 8 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm. A Lenz.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Alvina Vogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Albert H. Seim

(Address) 4403 Belvieu Ave

15 Filed [illegible] 19[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-5-30

17 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1929, to April 5, 1930, that I last saw h-e alive on April 4, 1930 and that death occurred, on the date stated above, at 12 05 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): metastasis to Lung

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Aug 1929

Was there an autopsy? No.

What test confirmed diagnosis? Clynical

(Signed) John H Evans, M. D.

19 (Address) 612 W 40 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls Violetville

DATE OF BURIAL: 4-7 1930

20 UNDERTAKER: Jno Chas A Rohde

ADDRESS: 2327 Edmondson Ave

Important.—See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55863

REGISTERED NO. E 55863

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 933 N. Patterson Park Ave. Ward 7-12)

2-FULL NAME Rudolph Frank Bolard

(a) RESIDENCE NO. 933 N. Patterson Park Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Antoinette Bolard

6 DATE OF BIRTH (month, day, and year) Aug 11/1872

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	57	7	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) Coal
(c) Name of employer Wilcox & Ziegler

9 BIRTHPLACE (city or town) (State or country) Balrto., Md.

PARENTS

10 NAME OF FATHER Anton Bolard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prague, Bohemia

12 MAIDEN NAME OF MOTHER Mary Tesar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Rudolph F. Bolard, Jr. (Address) 3120 Kenyon Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

APR 7 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5/30 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol Shot Wound right Temple
(Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

4/7/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	Apr 8 1930
20 UNDERTAKER	ADDRESS
August Tasch	2406 Ashland ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55864

E 55864

REGISTERED NO. 1883

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH 17

City of Baltimore: (No. Franklin Sq Hos St., 16-22 Ward)

2-FULL NAME Sherman Johnson

(a) RESIDENCE NO. 1023 N Stricker St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 10 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 20-1924

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	10	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) Baltd
(State or country) Md

PARENTS

10 NAME OF FATHER Malotis Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Pearl M Luck

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Pearl M Johnson
(Address) 1023 N. Stricker

15 Filed APR 7 1930 HAYDEN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck knocked down & run over while crossing street

I Fract Skull (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Calhoun & Mosher

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H H Hamm, M. D.

4/5, 1930 (Address) 2939 W Eldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 7 1930
20 UNDERTAKER Chas W Chase	ADDRESS 1400 Mosher

Must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55865

CERTIFICATE OF DEATH

66 E 55865

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 109 S Carlton St 1829 Ward)

2-FULL NAME Ernest Hayes

(a) RESIDENCE NO. 109 S Carlton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	unknown.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Police
(Address)

15 Filed 3-25-30 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24 1930

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O'Brien M. D.

3/25, 1930 (Address) 3601 3-hr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. | DATE OF BURIAL April 2, 1930

20 UNDERTAKER Lillie Zuke Inc. | ADDRESS 4038 Wolfe

APR 1 - 1930 HAMILTON JONES M.D.

Cor. should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55866

E 55866

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital St. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Burris

(a) RESIDENCE NO. 1820 Presstman ST., WARD 16
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C

PARENTS

10 NAME OF FATHER Clarence Burris Sr

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Steater

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. C

14 Informant Josephine Burris.
(Address) 1820 Presstman St

Filed 7-1930. C. HUMPHREYS JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4-30

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 4, 1930, that I last saw him alive on April 4, 1930 and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M McClain, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 4/7 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

Z 34847
E 55867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 55867

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 27-43 WARD)

2—FULL NAME Alexander Carroll

(a) RESIDENCE NO. 2904 Fleetwood Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida Carroll

6 DATE OF BIRTH (month, day, and year) 1907 Aug 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 66

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Esler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 7-1930 by H. A. Kelly, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1930, to April 5, 1930, that I last saw him alive on April 5, 1930 and that death occurred, on the date stated above, at 11 00 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension, Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Renal function tests

(Signed) Alexander Preston, M. D.

4/6, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Burna Vista Virginia

DATE OF BURIAL April 7 1930

20 UNDERTAKER Henry Lutz

ADDRESS 1203 N. Broadway

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55868

CERTIFICATE OF DEATH.

57 ✓ E 55868

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Baltimore Genl St. 16-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Lipsitz

(a) RESIDENCE NO. 3427 Park Heights Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob Lipsitz

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years 70 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joseph Yoffie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Hettie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address) 1429 E Balto St.

15 Filed ... 19... C. HARRISON JONES, M. D. Registrar

APPT - 10.0

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/6 1930

17

I HEREBY CERTIFY, That I attended deceased from 4/1, 1930, to 4/6, 1930,

that I last saw her alive on 4/6, 1930

and that death occurred, on the date stated above, at 9.40 A.M.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Endocarditis

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary): Diabetes mellitus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) S. A. Alessi, M. D.

4/6 1930 (Address) West Baltimore Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrer Rosedale

DATE OF BURIAL: 4/7 1930

UNDERTAKER: Jack Lewis 1429 E Balto St

ADDRESS

CAUSE OF DEATH must be stated plainly, so that a correct classification may be made by the Bureau of Vital Statistics. Each certificate must be signed by the physician who attended the deceased during his last illness, and he must state the time in which he last saw the deceased alive. If the death occurred without medical attendance, the coroner must be notified, and he will make the certificate. IMPORTANT—Read carefully the instructions on back of certificates. TION is very important See instructions on b

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 55869

REGISTERED NO. **E 55869**

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1819 W Pratt St. 19-28 Ward)

2-FULL NAME Mrs Minnie Kemp

(a) RESIDENCE NO. 1819 W Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos Kemp

6 DATE OF BIRTH (month, day, and year) Nov. 16 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	About 55	4	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER John Scott

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Robason

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mr Walter Smith
(Address) 2229 W. Pratt

15 Filed ... 19 ... E. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Brooke, M. D.

4/6. 1930 (Address) 3601 – 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Apr. 8 1930

20 UNDERTAKER George L. Schwab ADDRESS 501 Fulton Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55870

CERTIFICATE OF DEATH.

91-002

E 55870

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1843 W Baltimore ST. 14-28 WARD)

2-FULL NAME John Hauff.

(a) RESIDENCE NO. 1843 W Balto ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? 54 yrs. 6 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Hauff.

6 DATE OF BIRTH (month, day, and year) Sept. 15th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Agusta Hauff.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER E. Stumpff.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Elizabeth Hauff (Address) 1843 W Balto St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

R 7 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4-1930

17 I HEREBY CERTIFY, That I attended deceased from 10-30-1930, to 4-4-1930, that I last saw him alive on 4-4-1930, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral arteriosclerosis.

(duration) yrs. 5 mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Sc Demarce M. D.

(Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Apr. 8 19

20 UNDERTAKER George L Schwar.

ADDRESS 401 Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55871 E 55871

CERTIFICATE OF DEATH

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 Woodbourne Ave. (WARD) 27-48

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice L. Whipple

(a) RESIDENCE NO. 704 Woodbourne Ave. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry B. Whipple

6 DATE OF BIRTH (month, day, and year) Apr. 6, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sandy Hook Md.

PARENTS

10 NAME OF FATHER Ormand Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Alcinda M Hurdle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Wm A Butler
(Address) 704 Woodbourne Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5-1930

17 I HEREBY CERTIFY, That I attended deceased from Octr 10, 1929, to April 5, 1930,

that I last saw h.. alive on April 3, 1930,

and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Carcinoma of the intestines -

(duration) yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Cancer of Liver - Stomach -

(duration) 1 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Curtis F. Robinson, M. D.

5. 1930 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	Apr 7 1930
20 UNDERTAKER Wm Pickuer Sons	ADDRESS North & Pa

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55872

CERTIFICATE OF DEATH.

H5VE 55872

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No.) Caulem & Owrr ST. 15-68 (WARD)

2-FULL NAME Mrs Annie Moore

(a) RESIDENCE NO. 2703 Presbury ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gustavus J Moore

6 DATE OF BIRTH (month, day, and year): June 30, 1873

7 AGE — Years: 56 — Months: 9 — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Eleanor Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Gustavus Moore 2703 Presbury St

15 Filed APR 7 - 1930 Registrar S. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4 - 7 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 7, 1930, that I last saw her alive on April 6, 1930, and that death occurred, on the date stated above, at 1.50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Hepatic Flexure of Colon

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of April 5, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Vincent Messina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 4/9 1930

UNDERTAKER: Wm Cook — ADDRESS: 1210 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks

E 55873

E 55873 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 224 South Franklin St. (WARD) 20-69

2-FULL NAME William Roediger

(a) RESIDENCE NO. 224 South Franklin St. Road WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Catherine Roediger

6 DATE OF BIRTH (month, day, and year) June 24 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	80	9	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS
10 NAME OF FATHER Wm Roediger
11 BIRTHPLACE OF FATHER (city or town) (State or country) France
12 MAIDEN NAME OF MOTHER ? Back
13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Charles P. Dorsch
(Address) 538 St. Paul

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1930

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to April 5, 1930, that I last saw ~~him~~ alive on April 5, 1930, and that death occurred, on the date stated above, at 11 45 m.

The CAUSE OF DEATH* was as follows: Carcinoma Pleura Lung
Metastasis Myocarditis Chronic
Interstitial Nephritis

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) _____ yrs. _____ mos. _____ da.

18 Where was disease contracted if not at place of death? Yes
Did an operation precede death? No Date of _____
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Antonio C. Notch, M. D.
4/6/30 (Address) 2157 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery
DATE OF BURIAL 4/8 1930

20 UNDERTAKER Julian Cook
ADDRESS 1217 St Paul

TION is very important See instructions on back of certificates.

55874 ...S—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-98 E 55874

CERTIFICATE OF DEATH

1—PLACE OF DEATH Hospital for Women of Md. REGISTERED NO.

CITY OF BALTIMORE: (No. Lafayette Ave. & Johns St. 27) - 43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Robert Robertson

(a) RESIDENCE NO. Hosp. for Women of Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~5~~ Life mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) March 18, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	✓	✓	14	

8 OCCUPATION OF DECEASED ✓

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Francis Robertson

11 BIRTHPLACE OF FATHER (city or town) Mt. Vernon, (State or country) New York

12 MAIDEN NAME OF MOTHER Ruby Reta Combs

13 BIRTHPLACE OF MOTHER (city or town) Fredericton, (State or country) New Brunswick, Canada

14 Informant John Francis Robertson

(Address) 1421 Glyn Oak Ave.

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to April 6, 1930, that I last saw him alive on April 6, 1930 and that death occurred, on the date stated above, at 9.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema —

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pneumonia & Coronary Thrombosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hugh Wirth —, M. D.

..., 19... (Address) 16 E. Chase St —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL 4/7 1930

20 UNDERTAKER W. M. Cook

ADDRESS 129 E. Paul St

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

Dr Smink 4706 Harford Ave

E 55875 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55875

CERTIFICATE OF DEATH.

REGISTERED NO. 9246

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 E. 20th ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Angel

(a) RESIDENCE NO. 518 E. 20th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~or WIFE of~~ Annie Angel

6 DATE OF BIRTH (month, day, and year) 12/4/1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
75	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John T. Angel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF ~~Mary~~ J. Holbrooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Amanda C. Angel

(Address) 518 E. 20th St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6/1930

17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1930, to April 6, 1930, that I last saw ~~him~~ alive on April 6, 1930, and that death occurred, on the date stated above, at ~~4~~ m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Smink, M. D.

4/7, 1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL 4/8/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

APR 7 - H. [illegible] JONES, M.

Spec.—1-30—M. & T.—250 Bks.

E 55876 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 ✓ E 55876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 14-20 (WARD)

2-FULL NAME John Ed. Bell

(a) RESIDENCE No. 2030 Etting St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Carroll County Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant (Address) Records of Baltimore City Hospital

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4-30

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 1930, to 4/4, 1930, that I last saw him alive on 4/4, 1930, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Diffuse

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. Wilson, M. D.

4-4, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cem

DATE OF BURIAL 4-7-30

20 UNDERTAKER Emmett Brusley

ADDRESS Baltimore

HOME IS VERY important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55877 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55877

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2324 Gulford ST. 17-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles N. Harris

(a) RESIDENCE NO. 2324 Gulford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Harris

6 DATE OF BIRTH (month, day, and year): Jan. 20-1898

7 AGE — Years: 32 — Months: 2 — Days: 13 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Genral Labor

(b) General nature of industry, business, or establishment in which employed (or employer): Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): U.S. Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mary Harris 2324 Gulford Ave

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 3 30

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1930, to Apr 3, 1930, that I last saw h[er] alive on Apr 3, 1930 and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home of death

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? By Symptoms

(Signed) L. A. Johnson M. D.

, 19 (Address) 2329 Lemmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem

DATE OF BURIAL: 4/7 1930

20 UNDERTAKER: Samuel L. Hensley

ADDRESS 3718 Belle

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55878

CERTIFICATE OF DEATH

113 E 55878

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1509 Eastern St., 6-4 Ward)

2-FULL NAME Mildred Harris

(a) RESIDENCE NO. 1509 Eastern St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 10-1929.

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
1		26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant. Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Richard Harris

11 BIRTHPLACE OF FATHER (city or town) Del.
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Wolak.

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Catherine Harris
(Address) 1509 Eastern ave.

15 Filed ... 19.. Registrar

R 2-1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1a Gastro Enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Dilation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Inquiry Food

What test confirmed diagnosis?

(Signed) G. E. Wade M. D.

April 7 19 30 (Address) 732 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	April 7 1930
20 UNDERTAKER	ADDRESS
George A. Weber	705 S. Ann St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55879.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55879

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. ..... ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard James

(a) RESIDENCE NO. 2217 Oak St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lulu James

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER John James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Sarah Brawner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga.

14 Informant Records of
(Address) Baltimore City Hospital

15 Filed 4-7-1930 C. Hampton Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-3-30

17 I HEREBY CERTIFY, That I attended deceased from 2-27-30, 19..., to 4-3-30, 19..., that I last saw him alive on 4-3-30, 19..., and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic & acute

(duration) over 2 yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Hypertension Arteriosclerosis

(duration) over 2 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Harwin W. McLean M. D.

4-5, 1930 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkton Md.

DATE OF BURIAL 4-7 1930

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1705 Ashland Ave

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 55880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55880

161 002

REGISTERED NO.

1-PLACE ~~OF DEATH~~

CITY OF BALTIMORE: (No. West Balto Genl Hosp St. 5-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby girl Rossi

(a) RESIDENCE NO. West Baltimore, Genl Hosp WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. none mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/6/30

7 AGE: Years Months Days: stillborn — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Rossi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Elizabeth Del Zyro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Hospital Records (Address)

15 Filed APR 7-1930 19 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/6/30, 19 to 4/6, 19 30,

that I last saw ~~him~~ alive on 4/6, 19 30, at m.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage

asphyxia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intracranial hemorrhage (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. A Alessi, M. D.

19 (Address) West Balto Genl Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem

DATE OF BURIAL 4/9/30 19

20 UNDERTAKER X. Tray 1. Tuth

ADDRESS 1733 Hoff

CAUSE OF DEATH to be properly classified. Fill in all items, so that if may be transferred to back of certificates.

TION is very important See instructions on back

Cor.—10-10-29—A Co.—196 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55881

55881

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 2747 W La Fayette St., Ward) 30-69

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Binkley Klinefelter

(a) RESIDENCE NO. Lebanon. Pa St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residrnce in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan U. Klinefelter

6 DATE OF BIRTH (month, day, and year) Feb. 18-1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	33	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Contractor
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Lebanon
(State or country) Pa.

PARENTS

10 NAME OF FATHER Richard H. Klinefelter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Fannie Binkley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant (Address) Est of Klinefelter Lebanon. Pa.

15 Filed ..... 19 ..... C. HARRISON JONES, Registrar

APR 7 - 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest & Autopsy (Inquest, autopsy or inquiry.) the conclusions from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Hemorrhage due to pistol wound of lung and torso Suicidal

(duration) ..... yrs. Instantaneous

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 2747 W La Fayette

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Blair Smith Jr. M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side foe additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ebenezer Mem. Lebanon. Pa.	Apr 7 1930
UNDERTAKER Wm J Trickner & Sons	ADDRESS N. York Pa

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-001

E 55882

1—PLACE OF DEATH
CITY OF BALTIMORE: (No.) 842 Harford ave (St.) 10-14 (WARD) REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. apps

(a) RESIDENCE NO. 842 Harford ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel E. apps

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Samuel Copps
(Address) 842 Harford ave

15 Filed APR 7 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 19 30, to Apr 6, 19 ..., that I last saw h[e] alive on Apr 5, 19 30 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza (duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) B Harris, M. D.

4/7, 19 30 (Address) 310 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	April 9, 1930
20 UNDERTAKER Eduard Bryan	ADDRESS 1651 orleans st

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Jones

E 55883 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55883

CERTIFICATE OF DEATH. 129

REGISTERED NO. 27548

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6000 Ready Ave ST. WARD

2-FULL NAME Alfonso Station Jones

(a) RESIDENCE NO. 6000 Ready Ave ST., WARD 27

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. X mos. X ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	W. Irish	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Oct. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	6	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired Office

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Georgetown Jones

11 BIRTHPLACE OF FATHER (city or town) Mich Centre

(State or country) Mich

12 MAIDEN NAME OF MOTHER Norah Dwyer

13 BIRTHPLACE OF MOTHER (city or town) Mich

(State or country)

14 Informant Mrs Bessie Jones

(Address) 6706 Ready Ave

15 Filed APR 7 1930 C. HA[illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1930

17 I HEREBY CERTIFY, That I attended deceased from June 1929 to April 4 1930, that I last saw h[illegible] alive on April 4 1930, and that death occurred, on the date stated above, at 5 Pm m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

+ Bright's disease, Bright's disease

(duration) 1 yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Senility

(duration) 83 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? 6000 Ready Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr

(Signed) Dr H Benson, M. D.

(Address) 6010 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manitou Beach Mich. DATE OF BURIAL April 7 1930

UNDERTAKER Chas E. Franke ADDRESS 802 Washington Ave Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55884

CERTIFICATE OF DEATH

51 E 55884

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. WARD)

2—FULL NAME Mrs Helen Gassaway

(a) RESIDENCE NO. 1519 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of John H Gassaway

6 DATE OF BIRTH (month, day, and year) Apl 21 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co Md

PARENTS

10 NAME OF FATHER Otho Muscarlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet McGrade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Helen Gassaway

(Address) 1519 Linden Ave

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

APR 7 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 6/30

17 I HEREBY CERTIFY, That I attended deceased from 4-4- 1930, to 4-6 1930

that I last saw ~~her~~ alive on 4-6 1930

and that death occurred, on the date stated above, at 2 40 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas

Diabetes Mellitus

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? 1519 Linden Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood & urine Examination

(Signed) Vernon H Norwood, M. D.

19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date Hill Cemetery Washington Co. Apl 8 1930

DATE OF BURIAL

20 UNDERTAKER Myers & Nee

ADDRESS 1 N Broadway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 55885 — REGISTERED NO. — E 55885

1—PLACE OF DEATH Balto City Hospt

CITY OF BALTIMORE: (No. Balto Md ST. 17-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Etta or Ada Lomax

(a) RESIDENCE NO. 722 W. Franklin ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE — Years: 49 — Months — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records

(Address): Balto City Hospitals

15 Filed ....., 19.... C. HAMILTON BATES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-4-30

17 I HEREBY CERTIFY, That I attended deceased from 3-21-, 1930 to 4-4, 1930

that I last saw her alive on 4-3-, 1930

and that death occurred, on the date stated above, at 3.45 m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation —
Terminal Bronchopneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Harry Goldsmith M. D.

4-6, 1930 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fredericksburg Va — DATE OF BURIAL: 4-6 1930

20 UNDERTAKER: David Easton — ADDRESS: 96 Pa ave.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55886

1-PLACE OF DEATH

City of Baltimore: (No. Pronounced dead at Hopkins Hospital St. 10-14 Ward) 90

2-FULL NAME Pleasant Watkins

(a) RESIDENCE NO. 904 Hillman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

E 55886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	White	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant N.E.Police Dept.
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Disease
(Found on sidewalk of 904 Hillman St.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

4/4/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

THE MORGUE 1514

UNIVERSITY OF MARYLAND APR 7 - 1930

Be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55887

CERTIFICATE OF DEATH

90 E 55887

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp. St. 11-24 Ward)

2-FULL NAME F. Brewer

(a) RESIDENCE NO. Unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
about 45				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) X
(c) Name of employer 0

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Md Gen Hosp Record
(Address)

15 MAR 26, 1930 Mar Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Mar 25th 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.

Mar 26 1930 (Address) Crane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

...should be carefully supplied. Age, sh... ...that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND
APR 7 - 193[illegible]

MAR 27 1930
TO THE MORGUE

1-30—M & T.—100 B—50L

(Timothy Lees)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55888

CERTIFICATE OF DEATH

E 55888

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp ST. W-1 WARD)

2-FULL NAME Harry Dikun

(a) RESIDENCE NO unknown ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced (write the word) Dont Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dont Know
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant

(Address)

15 Filed ..... 192 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck down by motor auto

ac Fract Skull (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Lombard & Fallsway

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. J. Frank Co., M. D. (Coroner)

3/29 1930 (Address) 2439 W. Eddy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pachuses Cem.

DATE OF BURIAL 4/2/30

20 UNDERTAKER

ADDRESS

APR 7 - 1930

1512

THE MORGUE

UNIVERSITY OF MARYLAND

1930 C. Harrison Jones M.D.

Dr. Cook 1217

Dept. of Health

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55889

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55889

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No.) ST 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mike Sinyak (or Shuniak)

(a) RESIDENCE NO. 731 S. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Recordd of

(Address) Balto. City Hosp.

Filed APR 7 1930 19 3516 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-4-30

17 I HEREBY CERTIFY, That I attended deceased from 3-7-30, 19..., to 4-4-30, 19...,

that I last saw him alive on 4-4-30, 19...,

and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) over 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical: X-ray

(Signed) Marvin W. McLean, M. D.

4-4; 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER C. HAMPSON JONES, M. D. Commissioner Health.

ADDRESS APR 7 - 1930

TION IS very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55890

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55890

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Ridgely Pitcher

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) May 3, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	10	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer) 0?
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Ridgely

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Halie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-30

17 I HEREBY CERTIFY, That I attended deceased from 3-12-29, 19..., to 4-5-30, 19..., that I last saw him alive on 4-5-30, 19..., and that death occurred, on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) over 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marion M. McLean, M. D.

(Address) Balto. City Hosp. 4-6, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS APR 7 - 1930

[illegible] HAMPSON JONES, M. D.
[illegible] W. SARATOGA ST.

See instructions on back of certificates. IT IS VERY IMPORTANT

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55891 | CERTIFICATE OF DEATH | 164 E 55891

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1733 Linden Av ST. 4-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Virginia Tuxworth

(a) RESIDENCE NO. 1733 Linden Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. 5 mos. 3 ds. How long in U. S., if foreign birth 87 yrs. 5 mos. 3 da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: D. Howard Tuxworth

6 DATE OF BIRTH (month, day, and year): Nov-3-1842

7 AGE — Years: 87 | Months: 5 | Days: 3 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General natore of indostry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Stogg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Maryland

12 MAIDEN NAME OF MOTHER: Mary Woollen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Maryland

14 Informant: Dr. E. R. Quinby Jr. Sanitar.

(Address) 1733 Linden Ave

15 Filed ... 7 1930 ... 19 ... C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 6th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3 1930 to April 6th 1930

that I last saw h e alive on April 5th 1930

and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Old age — (over)

In last illness (doration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) None (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. R. Quinby Jr, M. D.

4-7-1930 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emt Mount Cemetery — DATE OF BURIAL: Apr. 8 1930.

20 UNDERTAKER: Stewart Monroe Co — ADDRESS: Balto.

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55892 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55892

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (ST. 76-37 WARD)

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Elliott

(a) RESIDENCE NO. Beltsville, P.G. Co., Md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Elliott

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER John Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp. M. D.

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-30

17 I HEREBY CERTIFY, That I attended deceased from 4-3-30, 19..., to 4-6-30, 19..., that I last saw him alive on 4-6-30, 19..., and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical, Autopsy

(Signed) Darwin M. Wiseal, M. D.

4-7, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C.

DATE OF BURIAL April 7, 1930

ADDRESS 1127 E Balto St

20 UNDERTAKER J. Lennon & Bro

THIS IS very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

Saveese

E 55893 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55893

CERTIFICATE OF DEATH.

154

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Saveese

(a) RESIDENCE NO. 221 N Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-6-30

7 AGE	Years	Months	Days	If LESS than 1 day, 10 hrs. 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed APR 7 1930, 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-30

17 I HEREBY CERTIFY, That I attended deceased from 4-6-, 1930, to 4-6, 1930, that I last saw her alive on 4-6, 1930, and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

1. Congenital Heart Lesion
2. Respiratory Cyanosis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Partial

What test confirmed diagnosis?

(Signed) Michael J Greenfield M. D.

, 19 (Address) Sinai Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 7 - 1930

SECTION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

E 55894 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55894

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 76 E. Eager St. 11-15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Rolfe

(a) RESIDENCE. No. 96 E. Eager St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Wilbur Fiske Rolfe

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1842

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N. H.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas J. Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Hoyge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Mrs. Virginia Rolfe Tel 96 E. Eager St.

15 Filed 7-1930 By C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1930

17

I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 6, 1930, that I last saw alive on April 6, 1930, and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic with acute dilatation of heart.

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis.

(duration) 13 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred H. Clark. M. D.

4/6, 1930 (Address) 3610 Smyrna Ave Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gloucester, Va.	4/8 1930
20 UNDERTAKER Harry L. Witzke 4101 Edmondson Ave.	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

E 55895 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55895

CERTIFICATE OF DEATH. X 148

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine White

(a) Residence No. Savage Md. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, ~~Widowed, or Divorced~~, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert A. White

6-DATE OF BIRTH (month, day and year) April 5, 1905

7-AGE. 17 yrs. mos. 7 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Will Fineshaw

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary Seargent

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Virgil White

(Address) Laurel Md.

15- Filed APR 7 1930 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH:

16-DATE OF DEATH (month, day and year) April 5 1930

17- I HEREBY CERTIFY, That I attended deceased from April 5 19 30 to April 7 19 30 that I last saw h.er alive on April 1 19 30, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Ante partum Eclampsia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home C.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel J. Holmes M. D.

19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Savage Md

DATE OF BURIAL. Apr 9 19 30

20-UNDERTAKER Lloyd Kaiser

ADDRESS Laurel Md

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

E 55896

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55896

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Rogers Av St. 27-54 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Elizabeth Johnston

(Residence in Baltimore: No. 2104 Rogers Av. St.; 60 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, April 21 (Month), (Day), 1849 (Year)

7-AGE, 80 yrs. 11 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Scotland

PARENTS.

10-NAME OF FATHER, William Downie

11-BIRTHPLACE OF FATHER (State or Country), Keith Scotland

12-MAIDEN NAME OF MOTHER Elizabeth Forsythe

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. John G. Franz

(Address) 2104 Rogers Ave.

15-

Filed ....., 191.....

C. HAMPSON JONES, M. D. Registrar.

7-1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 7 (Month) (Day), 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1927, to April 7 1930, that I saw h[illegible] alive on April 6 1930, and that death occurred, on the date stated above, at 8.30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial disease

(Duration) yrs. mos. 1 ds.

(Signed) Howard K. Warren M. D.

April 7, 1930 (Address) 2604 Garrison Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State 60 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cemetery

DATE OF BURIAL, Apr. 9, 1930

20-UNDERTAKER [illegible] Cook

ADDRESS 1003 West Baltimore St.

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 55897 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55897

CERTIFICATE OF DEATH.

90 H.B. Alley 130 Paul 2107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 903 S. Tuffle ST. 26-37 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bresnicke.

(a) RESIDENCE NO. 903 S. Tuffle ST. 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Bresnicke.

6 DATE OF BIRTH (month, day, and year) March 4 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith at Ore

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Copper Works.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Bresnicke

11 BIRTHPLACE OF FATHER (city or town) Austria (State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country)

14 Informant Marie Bresnicke (Wife)

(Address) 903 S. Tuffle St

15 Filed 4/7 1930 C. HAMPTON MOONEY M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th/30

17 I HEREBY CERTIFY, That I attended deceased from April 2 1930, to April 3 1930,

that I last saw h[illegible]ive on April 3 1930,

and that death occurred, on the date stated above, at 12.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Emphysema

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted? —

If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Henry B. Hatch M. D.

(Address) 2504 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	April 8 1930
20 UNDERTAKER	ADDRESS
Lilly & Julian Inc.	403 S. Wolfe St

TION is very important. See instructions on back of certificates.

R

Spec.—8-16-29—L. F. S.—100 Blks.

E 25898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 113 E 55898

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 15-56 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Mark Fava

(a) RESIDENCE NO. 3607 Reisterstown ST., Road WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17 1930

7 AGE: Years | Months 1 / 5 Weeks | Days 20 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——— (God)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md—

PARENTS

10 NAME OF FATHER Lindsey Fava

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Acero

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JONES HOPKINS HOSPITAL

15 Filed ___ 19 ___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar-22, 1930, to April 7, 1930, that I last saw h[e] alive on April 7, 1930, and that death occurred, on the date stated above, at 12 Noon a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 42 ds.

CONTRIBUTORY (Secondary) Rhino-pharyngitis; diarrhea

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) K. O. Y. Warren, M. D.

4/7, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: April 8, 1930

20 UNDERTAKER: Frank V. Siciliano — ADDRESS: 2815 E Balto

important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

Glorioso

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55899

E 55899

CERTIFICATE OF DEATH.

100-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital St. 114-30 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Glorioso.

(a) RESIDENCE NO. 1135 N. Fremont Ave St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 27 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W Lite	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Glorioso

6 DATE OF BIRTH (month, day, and year) Aug 28, 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Giglio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary [redacted]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [redacted]

14 Informant Katherine Lefevre
(Address) 1135 N Fremont Ave

15 Filed APR 7 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-30, 1930, to 4-5-, 1930, that I last saw her alive on 4-5-, 1930, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

. Pneumonia (Lobar)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 3-30-30

Was there an autopsy? no

What test confirmed diagnosis? Smear & culture

(Signed) [redacted], M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 9 1930
20 UNDERTAKER Frank V Pipetone	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55900 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 V E 559 0

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Park Avenue ST. (WARD) 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie C. Sheehan

(a) RESIDENCE NO. 1614 Park Avenue ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 0 mos. 7 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Sheehan

6 DATE OF BIRTH (month, day, and year) Mar. 30, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 027

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER James Chester

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Fannie Corrigan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant John M. Sheehan

(Address) 1614 Park Avenue

15 Filed ... Apr 19 ... C. HAMPSON JONES M. D. Registrar

APR 7 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7-30

17 I HEREBY CERTIFY, That I attended deceased from about 2 yrs. 19 ... to 4-6-30 ... 19 ...

that I last saw her alive on ... 4-6-30 ... 19 ...

and that death occurred, on the date stated above, at about 6 a.m. 9 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

about 2 yrs (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Leucemia

3 days (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. J. Finlay, M. D.

4-7-30 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4/24 19 30

20 UNDERTAKER Henry U. Myers' Son

ADDRESS 605 N. Calvert

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55901

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55901

CERTIFICATE OF DEATH.

REGISTERED NO. ....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Charles Apartments St. 12-49 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herbert C. Cole

(a) RESIDENCE NO. Charles Apartments ST., ... WARD New Orleans La

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelle Hynson

6 DATE OF BIRTH (month, day, and year) Dec. 14, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisiana

PARENTS

10 NAME OF FATHER John T. Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Maria Childress

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Estelle H. Cole

(Address) Charles Apartments

15 Filed ..... 19 ..... Registrar

R 7 1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7-30

17 I HEREBY CERTIFY, That I attended deceased from December, 1929, to apr. 7, 1930.

that I last saw h (~~he~~) alive on apr. 7, 1930,

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Angina Pectoris)

(duration) yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Electrocardiogram

(Signed) John T. King Jr. M. D.

, 19 (Address) 2194 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Orleans, La.

DATE OF BURIAL Apr. 8, 1930

20 UNDERTAKER John O. Mitchell & Sons, Mahler & Mitchell

ADDRESS 1900 Eutaw Place

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55902

CERTIFICATE OF DEATH

E 55902

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital WARD 49)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. ~~Jacob~~ Naomi J. Glatfelty

(a) RESIDENCE NO. Grantsville, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced (or) WIFE of Jacob J. Glatfelty.

6 DATE OF BIRTH (month, day, and year) May 16, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	51	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER J. C. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Nancy Engle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Thelma L. Frazier

(Address) Grantsville, Md.

15 Filed APR 7 1930, 19 Registrar C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1930, to April 7, 1930,

that I last saw her alive on April 7, 1930

and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Broca area L. side.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia, shock

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Grantsville, Md.

Did an operation precede death? Yes. Date of April 3, 1930

Was there an autopsy? No.

What tests confirmed diagnosis? Operative findings

(Signed) J. Carlton Wenborne, M. D.

19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grantsville Md	Apr 8 1930
20 UNDERTAKER John C. Mitchell Inc	ADDRESS Eutaw Pl

important. See instructions on back of certificates.

Cor—12-9-25—A Co—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55903

CERTIFICATE OF DEATH.

REGISTERED NO. E 55903

1-PLACE OF DEATH

City of BALTIMORE: (No. 133 N Duncan St. 6-10 Ward)

2-FULL NAME John T Hardester

(a) RESIDENCE NO. 133 N Duncan St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 23 1872

7 AGE: Years 57 Months 8 Days 13 IF LESS than 1 day.....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles C Hardester

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sarah E Pickering

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wash D C

14 Informant (Address): Elizabeth Hardester 2138 N Charles

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 6 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, au- Inquiry (Coroner or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:* Alcoholism Acute

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

Dr 4/30 (Signed) H C Blades M. D.

, 19 (Address) 1430 N Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

Date of Burial 4/9 1930

20 UNDERTAKER: J M Cook

ADDRESS 1112 E Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

Dr Tonry
414 E North Ave

E 55904 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55904

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 E. 21st ST. G-4-46 WARD)

2-FULL NAME Marion A. Thornton

(a) RESIDENCE NO. 513 E. 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Robert L. Thornton

6 DATE OF BIRTH (month, day, and year) April 29 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER George W. Benner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Robert L. Thornton (Address) 513 E 21st Street

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 23, 1930 to April 6 1930, that I last saw her alive on April 6 1930, and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Heart failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Tonry, M. D.

4-7-1930 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine

DATE OF BURIAL April 9, 30

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

E 55905

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Josephs Hospital REGISTERED NO. 90

CITY OF BALTIMORE: (No.) Caroline (St.) (Ward) 10-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellis Geraghty

(a) RESIDENCE NO. 601 E Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): About 1879

7 AGE: Years: About 51 Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): Household

(c) Name of employer: Mrs Kayer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Denis Geraghty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary McGovern

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Catherine Geraghty (Address) 236 E 88th New York City

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/7/30 19

17 I HEREBY CERTIFY, That I attended deceased from 3-6-30, 19 . to 4-6-30, 19 .

that I last saw h alive on 4-6-30, 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mns. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ,

Was there an autopsy? No

What test confirmed diagnosis? Clinical Con

(Signed) N B Goldring M. D.

, 19 (Address) 1 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 4/10/ 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

C. HAMPSON JONES, M. D.

APR 7 - 1930

Spec.—1-30—M. & T.—250 Bks.

E 55906 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55906

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (NO. ..... ST. 25-72 WARD)

2-FULL NAME Julia E. Bowen

(a) RESIDENCE NO. 2403 Georgetown Rd. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	3	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown 07
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Tyler Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of (Address) Baltimore City Hosp.

15 Filed 4-7-1930 C. HALLETT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-30

17 I HEREBY CERTIFY, That I attended deceased from 12-29-28, 19.., to 4-6-30, 19.., that I last saw him alive on 4-6-30, 19.., and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Chronic

(duration) 9 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 9 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hawin W. McLean, M. D.

4-7, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London park Cem

DATE OF BURIAL 4/9 1930

20 UNDERTAKER Wm Cook 1217

ADDRESS St Paul St

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55907

CERTIFICATE OF DEATH.

E 55907

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. West Baltimore St. 76-18 Ward

2-FULL NAME Cyrus Bachman

(a) RESIDENCE NO. Lebanon Pa St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE: 35 Years Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lumber Broker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Lebanon Pa

PARENTS

10 NAME OF FATHER: Cyrus Bachman

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Pa

12 MAIDEN NAME OF MOTHER: Essie Grady

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Pa

14 Informant: Arnold Funeral Home

(Address): 224 South 9th St Phila

15 Filed ....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest and Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Homicide Hemorrhage due to multiple lacerated wounds of face. Incised

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) H. Feath M. D.

(Coroner)

(Address)

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft. Lebanon Penna Date of Burial 4/8 1930

20 UNDERTAKER: H. M. Cork ADDRESS 1727 E. Fayette St

APR 7 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55908

CERTIFICATE OF DEATH

90 E 55908

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 717) Gay ST. 17-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Jane Clark

(a) RESIDENCE NO. 717 N Gay ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced, (or) WIFE of: Frank Clark

6 DATE OF BIRTH (month, day, and year): Dec 1867

7 AGE: Years 63 | Months 4 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Abingdon Md

PARENTS

10 NAME OF FATHER: Alfred Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Cockeran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Abingdon Md

14 Informant: Ida Spencer Laughton

(Address) 317 George St

15 Filed [illegible] 19 [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 5, 1930, that I last saw h[illegible] alive on April 5, 1930, and that death occurred, on the date stated above, at 1230 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Abingdon Cem. | DATE OF BURIAL: April 8 30

20 UNDERTAKER: Samuel Stansbury & Biddle | ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 55909

CERTIFICATE OF DEATH

E 55909

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1401 E North Ave ST., 9-18 WARD)

2—FULL NAME Susie A. Cummings

(a) RESIDENCE NO. 1401 E. Noll Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 2 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of John H. Cummings

6 DATE OF BIRTH (month, day, and year) Nov 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot County

PARENTS

10 NAME OF FATHER Tom Brownwell

11 BIRTHPLACE OF FATHER (city or town) Talbot County (State or country)

12 MAIDEN NAME OF MOTHER Walls

13 BIRTHPLACE OF MOTHER (city or town) Talbot County (State or country)

14 Informant J. Ralph Bridges

(Address) 2914 Harford Ave

15 Filed 4-[illegible], 19[illegible] [illegible] Registrar

4-8-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 7, 1930, that I last saw her alive on April 7, 1930 and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Chronic tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Frederic R.D. Wurtz, M. D.

, 19 (Address) 827 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Lilyhmans Md.	4/9/1930
20 UNDERTAKER Louis Neumann	ADDRESS 82 S. Broadway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55910

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55910

CERTIFICATE OF DEATH Brooklyn

REGISTERED NO. 2575

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3543 Hanover ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A Smith

(a) RESIDENCE NO. 3543 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 8 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F. M.	W	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Smith

6 DATE OF BIRTH (month, day, and year) Aug 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Appel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs William H. Smith

(Address) 3935 Hanover st

15 Filed APR 8 - 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. - 1929 to Apr. 5 1930

that I last saw h[illegible] alive on Apr. 4 1930

and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) 6 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Edward Novak, M. D.

19 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 8 1930
20 UNDERTAKER John F. Denny	ADDRESS 710 Light

Important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55911

CERTIFICATE OF DEATH

E 55911

REGISTERED NO. 28766

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 5209 Windsor Mill Rd St. 28th Ward)

2-FULL NAME Maurice Percy Smith

(a) RESIDENCE NO. 5209 Windsor Mill Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 11 mos. 25 da. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Susan E. Smith

6 DATE OF BIRTH (month, day, and year) Apr. 9, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	51	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Richard Smith

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Carnegan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs. Susie E. Smith

(Address) 5209 Windsor Mill Road

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 28, 1930, to Apr 4, 1930, that I last saw him alive on Apr 4, 1930, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) G. C. Lemmon, M. D.

Apr 7, 1930 (Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Loudon Park Cemetery	Apr. 8 1930.
20 UNDERTAKER John A. Henry	ADDRESS 15 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55912

CERTIFICATE OF DEATH

E 55912

REGISTERED NO. 161 004

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 11 E. Barney ST. 23-3 WARD)

2—FULL NAME Infant of William and Helen Waeters

(a) RESIDENCE NO. 11 E. Barney ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 3 1930

7 AGE — Years: — Months: — Days: 4 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: William Waeters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Helen Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: William Waeters

(Address): 11 E. Barney St.

15 Filed ..... 19 ..... Registrar: KHC.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3 1930 to April 7 1930 that I last saw her alive on April 7 1930 and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duratinn) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) K. H. Campbell M. D.

4/7 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem

DATE OF BURIAL: Apr 8 1930

20 UNDERTAKER: Fos Goerdens Son

ADDRESS: 2173 S. Pa

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

445 E. Eastern

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 V

E 55913

CERTIFICATE OF DEATH

E 55913

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 637 E. Eblemont ST. 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter H. LaBarre.

(a) RESIDENCE NO. 637 E. Eblemont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 2 mos. 26 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Irene I. Grossman

6 DATE OF BIRTH (month, day, and year): Jan 13 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tin Plate Repairer

(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. 073

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ellicott City Md.

PARENTS

10 NAME OF FATHER: Walter LaBarre

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Victoria Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ellicott City Md.

14 Informant: Irene I. LaBarre

(Address) 637 E. Eblemont St.

15 FILED 15 Registrar

C. HAMILTON SIMS, M. D.

3-8-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5/30

17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1929 to April 5 1930

that I last saw h[illegible] alive on April 5 1930

and that death occurred, on the date stated above, at 11-15 P. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of Heart (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no. What test confirmed djagnosis? Physical signs

(Signed) Sidney H. Street M. D.

4/7 1930 (Address) 445 E Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: 4/8/1930

20 UNDERTAKER: F. B. Wyatt. — ADDRESS: 150 N. Gallo St

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55914

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55914

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3132 Elliott ST., 1 WARD 1)

2-FULL NAME Ella M. E. Kues

(a) RESIDENCE NO. 3132 Elliott ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) april 15-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none yrs.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jacob F. Kues

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Daisy Reuse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Daisy Kues
(Address) 3132 Elliott St.

15 Filed APR 8 1928 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 7-1928

17 I HEREBY CERTIFY, That I attended deceased from 4-3-, 1928. to 4-6-, 1928.

that I last saw h alive on 4-6-, 1928,

and that death occurred, on the date stated above, at 4.50 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

Signed Carl V. Kelly M. D.

4/7, 1928 (Address) 1604 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem.

DATE OF BURIAL April 9 1928

UNDERTAKER George W. Zinkler

ADDRESS 1737 E. Eager St

IMPORTANT—See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 55915 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 55915

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 S Curley St. 11 WARD)

2-FULL NAME Cecelia Stewart

(a) RESIDENCE NO. 821 S. Curley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Stewart

6 DATE OF BIRTH (month, day, and year) Aug. 15-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	72	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Abbottstown, Md.

PARENTS

10 NAME OF FATHER Emanuel Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Alice Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant George Stewart (Address) 821 S. Curley St.

15 Filed APR 8 - 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6. 30

17 I HEREBY CERTIFY, That I attended deceased from Mar 1st, 1930, to April 6, 1930; that I last saw her alive on April 6 1930; and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma left breast.

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? C

(Signed) J Joseph Tousley M.D.

, 19 (Address) 1800 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL April 9 1930

20 UNDERTAKER George W. Zirkler ADDRESS 1737 E. Eager st

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55916

E 55916

CERTIFICATE OF DEATH.

76-37

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 S. Eaton ST., WARD)

2-FULL NAME Isabelle Kattenhorn

(a) RESIDENCE NO. 420 S. Eaton ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Kattenhorn

6 DATE OF BIRTH (month, day, and year) June 6-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home 37

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Wm. Gillchrist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Isabelle Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Frederick Kattenhorn

(Address) 420 S. Eaton St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5-1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to April 5, 1930,

that I last saw her alive on April 5, 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

Left Lung.

(duration) 1 yr. mo. da.

CONTRIBUTORY (Secondary) Heart Disease

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. McClenahan M. D.

4/7, 1930 (Address) 3500 Erick Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: April 8 1930

20 UNDERTAKER: George W. Zirkler — ADDRESS: 1737 E. Eager st.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55917

CERTIFICATE OF DEATH

101-001

E 55917
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 722 W. Saratoga St., 4-76 Ward)

2-FULL NAME Mamie Anthony

(a) RESIDENCE NO. 722 W. Saratoga St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

tion should be carefully supplied. AGE should be s

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Anthony

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or... min.
	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: John Shepherd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sarah Grayson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Hattie Shepherd
(Address) 1305 2 St. Wash. D.C.

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feltzt M. D.

4-7-1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D. C.	April 8 1930
20 UNDERTAKER: J. L. Brown & Son	ADDRESS: 1051 W. Monday

Bur O BK

Spec.—2-29-28—L. F. S.—500 Bks.

E 55918

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55918

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 N. Greene ST., 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline E. Adams.

(a) RESIDENCE NO. 328 N. Greene ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Adams.

6 DATE OF BIRTH (month, day, and year) Dec. 12, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Cumberland. Maryland.

PARENTS

10 NAME OF FATHER John Morrissey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Amanda Clark.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. Charles Raymer

(Address) 4014 Fairfax Rd.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

APR 8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 29 to Apr. 7 19 30

that I last saw h e alive on April 6 19 30

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardiovascular disease. 5

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) S. A. Timmonfield. M. D.

. 19 (Address) 306 N. Greene St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cumberland Md	April 10 1930
20 UNDERTAKER W. M. Conton	ADDRESS 2238 N Mts

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55919

E 55919 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 84

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 510 N Arlington Ave ~~ST.~~ 48-16 WARD)

2-FULL NAME Annie H. Jones

(a) RESIDENCE NO. 510 N Arlington Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	b	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 15, 48

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Phineas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Cecelia Mopley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs John Boston

(Address) Issued Md.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 30

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1930, to Apr 6, 1930, that I last saw h alive on Apr 6, 1930, and that death occurred, on the date stated above, at 6 — m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Old Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What teat confirmed diagnosis? Observation

(Signed) A. C. Smith, M. D.

(Address) 4509 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL April 8 1930

20 UNDERTAKER W M Rowlson

ADDRESS 2238 N Mtn

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55920

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 55920

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 2915 Cheslyn ave - ST. 21 Hamilton WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca M. Lenwood

(a) RESIDENCE NO. 2915 Cheslyn ave ST., Hamilton WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced (a) HUSBAND of (or) (b) WIFE of: Harry Lenwood

6 DATE OF BIRTH (month, day, and year) .....

7 AGE: 63 (Years / Months / Days / If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home mfr

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): York Co Pa

PARENTS

10 NAME OF FATHER: John W ack.

11 BIRTHPLACE OF FATHER (city or town) (State or country): York Co Pa

12 MAIDEN NAME OF MOTHER: Mary Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York Co Pa

14 Informant: Harry Lenwood

(Address) 2915 Cheslyn ave. Hamilton

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 6/1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929, to April 6, 1930, that I last saw HER alive on April 6, 1930 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 14 mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Feb. 15, 1929

Was there an autopsy? No

What test confirmed diagnosis? General findings

(Signed) H. L. Campbell M. D.

4/8, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: York, Pa Lutz

DATE OF BURIAL: Apl 9 1930

20 UNDERTAKER: Kopp & Zimmer

ADDRESS: W. Philey

important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55921 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 90 E 55921

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Aged Men's Home Lexington & Calhoun ST. 19-27 WARD)

2-FULL NAME Oliver E. Benson

(a) RESIDENCE No. Calhoun & Lexington Sts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 16, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel County Md.

PARENTS

10 NAME OF FATHER Joseph Benson

11 BIRTHPLACE OF FATHER (city or town) A.A. Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary S. Kelly

13 BIRTHPLACE OF MOTHER (city or town) A. A. Co. (State or country) Md.

14 Informant Mrs. Iola G. Stevens
(Address) Rochambeau Apartments

15 Filed APR 8 - 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930 to April 7, 1930.

that I last saw him alive on March 28, 1930.

and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin B. Jarrett, M. D.

, 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	Apr. 9, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw pl.

Mahlon B. Mitchell

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55922 11-00 E 55922

CERTIFICATE OF DEATH.

E 55922

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Cator Ave. St., 9-47 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Austin Valliant Courtenay

(a) RESIDENCE NO. 610 Cator Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estelle Courtenay

6 DATE OF BIRTH (month, day, and year) Aug. 22/1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) R. R. Claims

(c) Name of employer B. & O.

9 BIRTHPLACE (City or town) (State or country) Lonaconing Md.

PARENTS

10 NAME OF FATHER Austin M. Courtney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Florence Valliant

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Florence Orn (Address) 610 Cator Ave.

15 Filed APR 8- 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) April 6 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3 1930 to April 6 1930

that I last saw h / alive on April 6 1930

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumo.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Francis A Ellis, M. D.

, 19 (Address) 616 Dumbarton.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr. 10, 1930
20 UNDERTAKER John O Mitchell & Sons	ADDRESS 1900 Eutaw Place

CAUSE OF DEATH to be filled in plainly in ink, so that it will be legible on back of certificates.

TION is very important See instructions on back.

Spec. 1-30 M. & T. 250 M

E 55923 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55923

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3919 Edmondson Ave. (ST.) 20-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph K. Folckemmer

(a) RESIDENCE NO. 3919 Edmondson Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Grumbine

6 DATE OF BIRTH (month, day, and year) May 26, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Comm. artist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Isaac Folckemmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary Klinefelter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant (Address) Mrs. Anna G. Folckemmer 3919 Edmondson Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 6, 1930, that I last saw him alive on April 6, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Edw. Woerig, M. D.

, 19 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemy.	April 9 1930
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1900 Eutaw P

John O. Mitchell & Sons

TION is very important See instructions on back of certificates.

APR 8 - 1930 HAMPSON JONES, M. D.

E 55924

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55924

CERTIFICATE OF DEATH.

REGISTERED NO. 100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Gen Hosp (Street) 28-64 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Belle Fisher

(a) RESIDENCE NO. 5201 Gwynn Oak Ave (Street) (Ward)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13 1867

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
63	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER George Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mary Bennett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. F. Wilbur

(Address) 5201 Gwynn Oak Ave

15 Filed APR 8 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1930

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to April 7, 1930, that I last saw her alive on April 7, 1930 and that death occurred, on the date stated above, at 8 A. m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. 5 mos. 19 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) S. A. Alessi, M. D.

, 19 (Address) West Balto. Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Apl 9 1930

20 UNDERTAKER Richard E. Cole — ADDRESS 1723 W. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

E 55925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 V E 55925

REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. 1623 Druid Hill Ave ST., 30 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary R. Simms

(a) RESIDENCE NO. 1623 Druid Hill ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laurence Simms

6 DATE OF BIRTH (month, day, and year): Jan 31 1893

7 AGE: Years 37; Months; Days 5 4; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John Shaw
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ark Kansas
12 MAIDEN NAME OF MOTHER: Mary McCan
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Interment
(Address) Francis Darcy 1623 Druid Hill

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1930, to April 5, 1930, that I last saw her alive on April 5, 1930, and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis (duration) yrs. mos. da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) Fred Woolridge M. D.
4-7-1930 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: Apr 8 1930

20 UNDERTAKER: Hurst & Cocks — ADDRESS: 1302 Jefferson

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 55926

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55926

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N. Bruce St. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Elizabeth Culver

(a) RESIDENCE NO. 314 N. Bruce ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Culver

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Anne Arundel Co. Md.

PARENTS

10 NAME OF FATHER Abraham Hicks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne A. Co. Md.

12 MAIDEN NAME OF MOTHER Dillie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne A. Co. Md.

14 Informant William Culver (Address) 216 N. New York ave. Atlamtic City. N.J.

15 Filed 8 - 1930 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 19 30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 18 19 30 to April 6 19 30, that I last saw her alive on April 5 19 30, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Mitral Insuffiency

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ay place of death

Did an operation precede death? No (Date of)

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklij St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 4-8 1930

20 UNDERTAKER Daniel Easton

ADDRESS 716 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation of deceased is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks. Martha Fetrow

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55927

CERTIFICATE OF DEATH

129 ✓ E 55927

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 642 E. Clement St. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Fetrow

(a) RESIDENCE NO. 642 E. Clement ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harrisburg Pa.

PARENTS

10 NAME OF FATHER John Handiboe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Elizabeth Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mrs. Jos. Fetrow (Address) 642 E Clement

15 Filed 4-8-1930 C. HAMILTON SIMPS[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7-30

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929 to April 7, 1930, that I last saw h[illegible] alive on April 5, 1930 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Uremic coma & Cerebral Apoplexy

(duration) 1 yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis & Arteriosclerosis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Donahue M. D.

4/7 1930 (Address) 1 E Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harrisburg Pa.	4/9 1930
20 UNDERTAKER	ADDRESS
J. H. McCully	130 E Front

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55928

CERTIFICATE OF DEATH

129 ✓

E 55928

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 929 W Lexington ST. 18-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Rapp.

(a) RESIDENCE NO. 929 W Lexington ST.,

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Rapp

6 DATE OF BIRTH (month, day, and year) Sept 24 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 837

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Lehr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Rapp (Address) 929 W Lexington

15 Filed C. H. [illegible], M. D. Registrar

R 8 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4. 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 31. 1930, to April 4. 1930, that I last saw h[illegible] alive on April 4th 1930 and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam etc

(Signed) Thos. Norton, M. D.

4/30 19 (Address) 338 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 8 1930
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 55929

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55929

CERTIFICATE OF DEATH.

37

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 240 N Amity St. 18-76 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Matthews

(a) RESIDENCE NO. 240 N. Amity St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mary Matthews

6 DATE OF BIRTH (month, day, and year) April 9 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bucks Md

PARENTS

10 NAME OF FATHER Major Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Jane Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frank Matthews (Address) 240 N. Amity St.

15 Filed APR 8 1930 H. [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jany 12 1930, to April 6, 1930, that I last saw him alive on April 5, 1930, and that death occurred, on the date stated above, at 5:00 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? regular

(Signed) W. F. Havilet M. D.

4/7 1930 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL April 7, 1930

20 UNDERTAKER Mrs Kate R. Williams — ADDRESS 322 N Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 55930 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55930

100-601

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 842 Vine St. ST. 18-26 WARD)

2-FULL NAME Georgia Bailey

(a) RESIDENCE NO. 842 Vine St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	15 3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pocahontas

PARENTS

10 NAME OF FATHER Jno Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Lizzie Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lizzie Bailey
(Address) 842 Vine St

15 Filed ..... 19 .... RLW Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-1930

17 I HEREBY CERTIFY, That I attended deceased from 4-2-, 1930, to 4-6-, 1930,

that I last saw h.. alive on 4-5-, 1930

and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
(Primary)
(duration) yrs. mos 6 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. L. Jackson M. D.

, 19 (Address) Coon Chicken Inman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: April 8 1930

20 UNDERTAKER: Mrs Katie C. Williams

ADDRESS 3224 Schroeder St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55931 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55931

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Arlington Ave ST., 27 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Sims

(a) RESIDENCE NO. 2309 Arlington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Sims

6 DATE OF BIRTH (month, day, and year) 12-9-1854

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
75	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer) The Hub. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Conrad Sinty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Eliz Henkers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Clara Dill

(Address) 2309 Arlington Ave

15 Filed APR 8 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-30

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1930, to April 6th, 1930, that I last saw her alive on April 5th, 1930, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows: Chronic Parenchymatous Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) F. J. Grady M. D.

4-7, 1930 (Address) 4218 Harford Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	4/8/30 19
20 UNDERTAKER Mary T. Pugh	ADDRESS 1135 Hanford Ave

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55932

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55932

11400

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (NO. ..... ST. 3-5 WARD)

2-FULL NAME Natale Ferrari

(a) RESIDENCE NO. 1205 Gough ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) July 29/81

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Louis

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Fobell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Hospital Records (Address)

15 Filed ..... 19 ..... Registrar .....

APR 8 - 1930 HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7-30

17 I HEREBY CERTIFY, That I attended deceased from 3-17, 1930, to 4-7, 1930, that I last saw h[illegible] alive on 4-7, 1930, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Epigastric hernia

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-2-30 4-6 —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J Leyko M. D.

4/7, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Aug 9 1930

20 UNDERTAKER Wendel & Leypold

ADDRESS 2000 Eden St.

CAUSE OF DEATH should be plainly written, and the answers to all questions should be full and complete. See instructions on back of certificates. IMPORTANT.

Spec.—8-16-29—L. F. S.—100 Blks.

Rich Marshall

E 55933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55933

REGISTERED NO. [illegible]

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 4-30 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rich Marshall

(a) RESIDENCE NO. Mechanicsville, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Marshall

6 DATE OF BIRTH (month, day and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waterman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mechanicsville, Md.

PARENTS

10 NAME OF FATHER Major B. Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Malissa Covington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Record

(Address)

15 Filed ..... 19.... HAMILTON JONES, M. D. Registrar

HR 8-1939

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1929, to April 5, 1930, that I last saw h/M alive on April 5, 1930 and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical.

What test confirmed diagnosis?

(Signed) Wm. Draper, M. D.

(Address) University Hospital 4-8 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Vienna Md.

DATE OF BURIAL 4-8 1930

20 UNDERTAKER B C Clark

ADDRESS 1000 S Broadway St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 55934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 55934

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Temple Garden Apts. # 7st 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Brafman

(a) RESIDENCE NO. (Usual place of abode) Temple Garden Apts. #7. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Jacob Brafman

6 DATE OF BIRTH (month, day, and year): March 25th. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore. Md.

PARENTS

10 NAME OF FATHER: ? Freidenrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Jacob Brafman

(Address): Temple Garden Apts.

15 Filed APR 8 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7th. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1929, to April 7, 1930, that I last saw h alive on April 7, 1930 and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) J. Frederick Leitz, M. D.

April 7, 30 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Shalom Cemetery

DATE OF BURIAL: 4/9/ 1930

20 UNDERTAKER: Harid Sondheim

ADDRESS 115-20 nd Nat. Royal Ave.

important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 55935

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

E 55935

1-PLACE OF DEATH

City of BALTIMORE: (No. 815 Warner St. 22-30 Ward)

2-FULL NAME Ella Frazier

(a) RESIDENCE NO. 815 Warner St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Fe	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Frazier

6 DATE OF BIRTH (month, day, and year) June 1888

7 AGE Yrs.	Months	Days	IF LESS than 1 day ....hrs. or ....min.
41	10	(1)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) N. C.

(State or country)

PARENTS

10 NAME OF FATHER Geo. Garner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) N. C.

12 MAIDEN NAME OF MOTHER Rebecca Whitehead

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) N. C.

14 Informant Wm Frazier

(Address) 815 Warner St

15 Filed ..... 19.. Registrar

APR 6 - 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 5 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 26 1930 to Apr. 5 1930, that I last saw h.r alive on Apr. 5 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. H. Counsell, M. D.

4/7 1930 (Address) 830 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn 4-9 1930 Date of Burial

ADDRESS

20 UNDERTAKER Joseph A. Lively 1019 N. Mount St

Stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

tion should be carefully supplied. AGE should be stated

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

V-9-003

13 E 55936

E 55936

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 409 Marland St. 47-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Connelly

(a) Residence No. 409 Marland Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S. (If foreign birth) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Sgle

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Apl 5-1930

7-AGE yrs. mos. 3 ds. If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9-BIRTHPLACE (City or town) (State or Country) Balt Md

PARENTS

10-NAME OF FATHER James Connelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Balto.

12-MAIDEN NAME OF MOTHER Matilda Edwards

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Balto

14- (Informant) Mrs. Connelly

(Address) 409 Marland Ave

15- Filed 1930 By C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 8-30

17- I HEREBY CERTIFY, That I attended deceased from April 5 1930 to April 8 1930

that I last saw him alive on April 8 1930

and that death occurred, on the date stated above, at 10.10 A m

The CAUSE OF DEATH* was as follows:

Cerebral Hemmhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Child

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S W Bishop M. D.

April 8, 1930 (Address) 521 Shenandoah

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St Mary Govans — DATE OF BURIAL. April 8 1930

20-UNDERTAKER Mary V. Warfield — ADDRESS 501 E. 22nd St

In plain terms, so that it may be properly classified. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

8

Spec.—8-16-29—L. P. S.—100 Blks.

E 55937

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 155937

E 55937

CERTIFICATE OF DEATH

F 101-00

1—PLACE OF DEATH

REGISTERED NO. _____

CITY OF BALTIMORE: (No. University Hosp. St. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin Hoyt Smith

(a) RESIDENCE NO. New York City St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances M. Smith

6 DATE OF BIRTH (month, day, and year): Aug-18-1866

7 AGE: Years 63 | Months 8 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mfgr of Surg 45

(b) General nature of industry, business, or establishment in which employed (or employer): Pharmacy Supplies

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Annapolis Maryland

PARENTS

10 NAME OF FATHER: Martin M Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Maryland

12 MAIDEN NAME OF MOTHER: Kathleen Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Maryland

14 Informant: Mrs Frances M Smith (wife)

(Address) 88 Central Park West-NY.

15 Filed _____, 19_____ _____ Registrar

R 8 - 1930

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 8, 1930, that I last saw h[illegible] alive on April 5, 1930 and that death occurred, on the date stated above, at 8 55 A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George H. Yeager, M. D.

Apr. 8, 1930 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York - NY. DATE OF BURIAL: Apr 8 1930

20 UNDERTAKER: Stewart & Conn Co ADDRESS: Balto

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55938

E 55938

CERTIFICATE OF DEATH

REGISTERED NO. 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 S. Mount ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edgar E. Chapman

(a) RESIDENCE NO. 320 S Mount ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of Ella, E. Chapman.

6 DATE OF BIRTH (month, day, and year) May 26 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
42.	41	10.	11.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed.

(b) General nature of industry, business, or establishment in which employed (or employer) 087

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James. Mc.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winchester Va.

12 MAIDEN NAME OF MOTHER Mary C. Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md.

14 Informant Mrs. H Chapman

(Address) 2022 Pendose ave.

15 Filed ... 19 ... Registrar

R 8-1930 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7-30

17 I HEREBY CERTIFY, That I attended deceased from December 1 1929 to April 7 1930

that I last saw him alive on April 7 1930

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Pulmonary Endocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Robert E. Kelch, M. D.

4/8/30 (Address) 2157 Wilson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Crem

20 UNDERTAKER Robert Brooks & Son

DATE OF BURIAL 4/9th 1930

ADDRESS Calhoun & Hollins sts

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks Annie Pooles ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55939 E 55939

CERTIFICATE OF DEATH. 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Lanvale ST. 16-22 WARD)

2-FULL NAME Annie Pooles

(a) RESIDENCE NO. 1520 Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 27 1911

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
18	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westminster S.C.

PARENTS

10 NAME OF FATHER Early C. Pooles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Westminster S.C.

12 MAIDEN NAME OF MOTHER Josephine Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Westminster S.C.

14 Informant Early C. Pooles (Address) 1520 Lanvale St.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-30

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1929 to 4-6, 1930.

that I last saw her alive on 4-6, 1930.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Chronic pulmonary phthysis

about (duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Confirmed

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington D.C.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Frank D Saunders, M. D.

4-8-1930 (Address) 1029 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 9 1930
20 UNDERTAKER Sam'l W Peace & Son	ADDRESS 1406 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

R 8 -1930 HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55940

CERTIFICATE OF DEATH

101-001

E 55940

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 916 (Street) St Barnabas (WARD) 6 17-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Malinda Games

(a) RESIDENCE NO. 916 St. Barnabas WARD 6

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Games

6 DATE OF BIRTH (month, day, and year) Unknown-79

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 370

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Natural

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Jones

(Address) 916 St. Barnabas

15 Filed APR 8 - 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 - 30

17 I HEREBY CERTIFY, That I attended deceased from April 3 1930, to April 7 1930, that I last saw h[illegible] alive on April 7 1930 and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Arter Sclerosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Carter, M. D.

(Address) 1[illegible] Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL: Apr 11 1930

20 UNDERTAKER: Wm H. Chase & Son — ADDRESS: 400 Mosher

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 ✓

E 55941

CERTIFICATE OF DEATH

E 55941

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 N. Carey ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Fred Hallhall

(a) RESIDENCE NO. 625 N. Carey ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9-1925

7 AGE — Years: 5 — Months: — Days: 28 — If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ottaway Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Annie Hallhall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Annie Hallhall

(Address) 625 N. Carey

15 Filed ___ 19 ___ Registrar

R 8-1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 7-1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 4, 1930, to Apr. 7, 1930

that I last saw h[illegible] alive on Apr. 7, 1930

and that death occurred, on the date stated above, at ___ m.

The CAUSE OF DEATH* was as follows:

Auto Toxemia 2 da.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) ___ yrs. ___ mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Humphreys M. D.

4-8, 1930 (Address) 1012 N. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Blackstone Va

DATE OF BURIAL: Apr 9 19 30

20 UNDERTAKER: Wm H Cruse & Son

ADDRESS: 1400 Madison

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55942

REGISTERED NO. 148 E 55942

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1925 N. Caulbert St.) 4-20 (Ward)

2-FULL NAME Christina Jones

(a) RESIDENCE NO. 1931 N. Caulbert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Richard Jones

6 DATE OF BIRTH (month, day, and year) Dec 23-1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Silas Berry

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Seabury

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Silas Berry
(Address) 1924 N. Caulbert St

15 Filed APR 8 - 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) C. H. Jones, M. D.

(Address) 1924 N. Caulbert St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Apr 9 1930
20 UNDERTAKER	ADDRESS
Wm. M. Chase & Son	1104 Madison

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 55943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 55943

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 Gilmore ST., 19-27 WARD)

2-FULL NAME Carrie Lee McQueen

(a) RESIDENCE NO. 531 Gilmore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: 6

6 DATE OF BIRTH (month, day, and year): Nov 10-1920

7 AGE: Years 10 Months 6 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: J. B. McQueen

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Jeabo Law

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Rev. McQueen

(Address): 531 Gilmore

Filed APR 8 - 1930, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 6, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 1st, 1930, to Apr 6, 1930,

that I last saw h alive on Apr 6, 1930,

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis.

Myocarditis.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Pneumonic Hemo.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. B. French M.D., M. D.

4/8, 1930 (Address) 707 Edmonson Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baxton, N. C.

DATE OF BURIAL: 4/9/1930

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1611 Druid Hill Ave

C. HAMPSON, M. D.

MATION should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

(Uebelen)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55944

CERTIFICATE OF DEATH

188-30-3

E 55944

1-PLACE OF DEATH

City of Baltimore: (No.) Balto City Hospitals St., 7-7-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Nebelen

(a) RESIDENCE NO. 111 N Lee St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	IF LESS than 1 day hr. or min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cigar
(b) General nature of industry, business, or establishment in which employed (or employer) Cork maker
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Don't Know

14 Informant Wife
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Auto in which he was a ride overturned catching him between

as Truck (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Skull

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Turkey Point Essex

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Frank Eby, M. D.

4/8 1930 (Address) 2139 W. Eddy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 9 1930
20 UNDERTAKER	ADDRESS
F. A. Krause & Son	103 Hanover St

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55945

CERTIFICATE OF DEATH

× 182 E 55945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Found Pin 4 Pratt Sts. Millie Galbreth — St., 3-5 Ward)

2-FULL NAME

(a) RESIDENCE NO. 97 9299. Pratt St., Ward Raiford N. C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4-1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	92			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Raiford N. C.
(State or country)

PARENTS

10 NAME OF FATHER Jno Galbreth

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Alice Boohman

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Dan Galbreth
(Address) 514 Argyle

15 Filed APR 8 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 4-1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Drowned
Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. T. Fuller, M. D.

April 5, 1930 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	4-9-30
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Madison St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

Dr Hess, York Rd V

E 55946

E 55946 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-00

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Edgewood Sanatorium ST. 27-48 WARD

2-FULL NAME Lillie W Jory.

(a) RESIDENCE NO. Edgewood Sanatorium ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Joseph Dorsey.

6 DATE OF BIRTH (month, day, and year) Aug. 14, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Towson, Md
(State or country)

PARENTS

10 NAME OF FATHER George W Hamilton

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Elizabeth Watkins

13 BIRTHPLACE OF MOTHER (city or town) Towson, Md
(State or country)

14 Informant Jamie M Myers
(Address) 1104 Druid Park Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1928, to April 7, 1930, that I last saw h alive on April 7, 1930, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. ... mos ... da.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hess, M. D.

48, 1930 (Address) 5000 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian, Govans

DATE OF BURIAL 4/10 1930

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55947

E 55947

CERTIFICATE OF DEATH. 185

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General Hosp. St. 13-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Allen C Robey

(a) RESIDENCE NO. 1820 Walbrook Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE: Anne C Robey

6 DATE OF BIRTH (month, day, and year): Jan 26 1859

7 AGE: Years 71 Months 2 Days 11 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Charles Co Md

PARENTS

10 NAME OF FATHER: John C Robey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER: Fannie Willett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant (Address): Annie C Robey 1820 Walbrook Ave

15 Filed ..... 19 ..... Registrar

R 8 1830

C. HARRISON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry and that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows: Acute dilation of the Cerebral Congestion & Heart. Congestion of head & face Acute Myocarditis Insufficiency Duration

CONTRIBUTORY (Secondary) Fall, Duration yrs. mos. ds.

(Signed) C. Harrison Jones M. D.

Apr 9 (Address) Coroner

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial 4/10/1930

20 UNDERTAKER: W. Cook — ADDRESS 1710 Eutaw St

tion should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks

Dr Tonry 814 E. North Ave

E 55948

E 55948 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 2119 Kirk Ave ST., 9-46 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gretchen King

(a) RESIDENCE NO. 2119 Kirk Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of or) WIFE of Neal Irwin King

6 DATE OF BIRTH (month, day, and year) Nov 30th 1881

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Holland

PARENTS

10 NAME OF FATHER Garrett Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Neal Irwin King

(Address) 2119 Kirk Ave

15 Filed APR 8 1930 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/30

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to April 8th, 1930, that I last saw her alive on April 5th, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (duration) 2 yrs. moe da.

CONTRIBUTORY (Secondary) Odema of Lungs (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S. Tonry M. D.

4-8, 1930 (Address) 414 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 4/10/1930

20 UNDERTAKER Wm Cook 1217 St Paul St — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55949

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55949

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Rigo

(a) RESIDENCE NO. 1517 Gough St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	0	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Nick Rigo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine La Magra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Josephine Rigo
(Address) 1517 Gough St

15 Filed APR 9 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 7, 1930, that I last saw her alive on April 7, 1930, and that death occurred, on the date stated above, at 6 15 a.m.

The CAUSE OF DEATH* was as follows:

Cheknepox

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Encephalitis, acute (probably)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No

Was there an autopsy? Refused Date of

What test confirmed diagnosis? Clinical

(Signed) Myron G. Tull, M. D.

4/8, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

20 UNDERTAKER Wendell J Dippel

DATE OF BURIAL April 9 1930

ADDRESS 300 S Eden ST

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

C. HAMPSON JONES, M.

APR 9 1930

Cor.—12-9-25—A Co.—[illegible] Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55950

CERTIFICATE OF DEATH.

90 E 55950

1-PLACE OF DEATH Declared dead at

City of BALTIMORE: (No. St. Joseph Hospital St. 27-43 Ward)

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary F. Saith

(a) RESIDENCE NO. 5520 Sefton Ave. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) About 1865.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	65.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER ------Smith.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER I Dont know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Louis F. Reisinger

(Address) 5520 Sefton St.

15 Filed C. HAMPSON JONES M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, Autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Disease

(Fell on Hamilton Ave nr Rana Ave)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. R. Calm M. D.

(Coroner)

4/8/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem Date of Burial April 10, 1930

20 UNDERTAKER A. Howard Evans ADDRESS 38 E. Fort Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55951

E 55951

CERTIFICATE OF DEATH

113

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2507 Oswego Ave ST. 15-58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Kenneth Crawford.

(a) RESIDENCE NO. 2507 Oswego Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	1	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Irvin W. Crawford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER A. Koelbl.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Irvin W. Crawford.

(Address) 2507 Oswego Ave.

15 Filed ___ 19 ___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7/30.

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1930, to Apr 7, 1930, that I last saw h alive on Apr 7, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Bronco pneumonia

& Mal. Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C W Meyer M. D.

4/8/1930 (Address) 15 N E 32

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL 4/9/1930

20 UNDERTAKER L. Vernon Lemmon

ADDRESS 4513 Park Heights Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

C. WILLISON JONES, M. D.

9 - 1930

Spec.—1-30—M. & T.—250 Bks.

E 55952

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55952

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 14-20 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Luther Pinkney

(a) RESIDENCE NO. 503 McMechin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House man 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Lyman Pinkney

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Records of

(Address) Baltimore City Hosp.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

R 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-30

17 I HEREBY CERTIFY, That I attended deceased from 3-29-30, 19..., to 4-5-30, 19...,

that I last saw him alive on 4-5-30, 19...,

and that death occurred, on the date stated above, at 5:10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, organic Vascular

(duration) 2½ yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis, organic Chronic

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Shawn M. McLean, M. D.

4-7, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood D. C.

DATE OF BURIAL 4-9 1930

20 UNDERTAKER Samuel I. Hemsley

ADDRESS 578 N. Bdle

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55953

CERTIFICATE OF DEATH

E 55953

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 576 W. Preston St. 17-24 Ward)

2-FULL NAME Stephan F. Carr

(a) RESIDENCE NO. 576 W Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Carr

6 DATE OF BIRTH (month, day and year): 1870

7 AGE: Years 60 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Helper in Stable
(b) General nature of industry, business, or establishment in which employed (or employer): 024
(c) Name of employer

9 BIRTHPLACE (city or town): Cambridge
(State or country): Md.

PARENTS

10 NAME OF FATHER: Carr

11 BIRTHPLACE OF FATHER (city or town): Kentucky
(State or country): Ky.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Cambridge
(State or country): Md.

14 Informant: Annie Carr
(Address): 576 W. Preston

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 19 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Coroner, Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Bonn M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem.

DATE OF BURIAL: March 19 30

20 UNDERTAKER: Samuel T. Hemley

ADDRESS: 5 B Mt. Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55954 ✓E 55954

CERTIFICATE OF DEATH

49

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Josephine Poe

(a) RESIDENCE NO. 1255 James St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Alonzo Poe

6 DATE OF BIRTH (month, day, and year) Jan. 25, 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James E. Wagson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Stallings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant J. Alonzo Poe

(Address) 1255 James St.

15 Filed APR 9 1930, 19 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 18, 1930, to April 8, 1930, that I last saw h(e)(r) alive on April 8, 1930 and that death occurred, on the date stated above, at 4 15 A. m.

The CAUSE OF DEATH* was as follows:

Primary malignancy of lung (bronchus)

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George H. Yeager M. D.

Apr. 9 1930 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine K. Cem.

DATE OF BURIAL 4/10/30 19

20 UNDERTAKER Harry N. Weitzel Co. ADDRESS 410 Edmondson Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55955

CERTIFICATE OF DEATH

74-001

E 55955

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1422 Division St. Ward) W-20

2-FULL NAME Chas. Clayton

(a) RESIDENCE NO. 1422 Division St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): 1890.

7 AGE: Years: About 40 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Daisy Sharp
(Address) 1422 Division St

15 Filed ....., 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 5th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and autopsy find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible] Cemetery	4-9 1930
20 UNDERTAKER	ADDRESS
David Earl	[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 5 - 1930

Spec.—1-30—M. & T.—250 Bks.

E 55956 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55956

89

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2356 E. Monument ST. 8th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas G. Lambros

(a) RESIDENCE NO. 2356 E. Monument ST., and WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Lambros

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 819

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Samuel Lambros (Address) 2356 E. Monument ave

15 Filed 9-1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7-1930

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to Apr 7, 1930

that I last saw him alive on Apr 7, 1930

and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Nathan O Kelford, M. D.

(Address) 1170 E. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	4-4-30

20 UNDERTAKER Daniel Kelly ADDRESS 716 Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55957 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55957

CERTIFICATE OF DEATH.

REGISTERED NO. 31V

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 17-25 ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel (Simon?) Mays

(a) RESIDENCE NO. 458 W. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1867?

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
63?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) Ga.

PARENTS

10 NAME OF FATHER Charles Mays

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Ga.

12 MAIDEN NAME OF MOTHER Birsey ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Ga.

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed 9-1920 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7-30

17 I HEREBY CERTIFY, That I attended deceased from 12-5, 1929, to 4-7, 1930,

that I last saw him alive on 4-7, 1930,

and that death occurred, on the date stated above, at 9-30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 4? mos ds.

CONTRIBUTORY (Secondary) Cirrhosis of Liver ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical: Autopsy

(Signed) Warren H. McLean, M. D.

4-8, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 4-9 1930

20 UNDERTAKER Daniel Corbin Dec — ADDRESS 916

CAUSE OF DEATH must be plainly written, so that it may be properly classified. See Instructions on back of certificates.

TION is very important

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55958

CERTIFICATE OF DEATH

185 ✓E 55958

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp St. 7-13 Ward)

2-FULL NAME Mrs Mary J Guthrie

(a) RESIDENCE NO. 1712 N. Carlton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): wid

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Joseph Guthrie

6 DATE OF BIRTH (month, day, and year): Sept 7 or 1862

7 AGE: Years 64 | Months 7 | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housk 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: L A Boden

11 BIRTHPLACE OF FATHER (city or town): —
(State or country)

12 MAIDEN NAME OF MOTHER: Mary A. Boden

13 BIRTHPLACE OF MOTHER (city or town): "
(State or country)

14 Informant: Brother
(Address): 713 N Carolines

15 Filed ..... 19..... C. HUMPSON JONES, M. D. Registrar

APR 9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 7 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and (from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Primary) Pneumonia

2 dys (duration)

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) A. J. Quinn, M. D.

Apr 9, 1930 (Address) 1179 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Catholic	Apr 10 1930
20 UNDERTAKER	ADDRESS
Geo M Frick & Son	811 N Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

...-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55959

CERTIFICATE OF DEATH

188-001 E 55959

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bayard St & B & O R.R. St., 23-32 Ward)

2-FULL NAME Horace G. Black

(a) RESIDENCE NO. 1503 S. Hanover St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 16 - 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
58 59	7	19		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Pa

PARENTS

10 NAME OF FATHER Samuel E. Black

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Pa

12 MAIDEN NAME OF MOTHER Adelaide Rhodes

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Pa

14 Informant Oliver J. Black
(Address) 1503 Hanover St

15 Filed ....., 19.... Registrar

R 9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushing wounds of legs. Fractured Skull. Struck by B & O train. Accidental Death (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Grillo M. D.

4/8. 1930 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	4/10/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

...SK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 55960

REGISTERED NO. E 55960

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St. (or Ward)

2-FULL NAME Eugene H. Keefer.

(a) RESIDENCE NO. 12 E. Henriette St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 8, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs or ..... min.
	1	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employrr

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Arlie E. Keefer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Frederick, Md.

12 MAIDEN NAME OF MOTHER Bertha M. Stropp.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md
(State or country)

14 Informant Arlie E. Keefer. (father)
(Address) 12 E. Henriette St.

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy and inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Convicted by Coroner's Jury April 11, 1930

Acute Gastritis.

Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 12 E. Henrietta St.

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What (test, confirmed) diagnosis? Autopsy & Inquiry

(Signed) Otto L. Reinhardt, M. D.

4/8, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Park Cemetery

DATE OF BURIAL Apl 9 1930

20 UNDERTAKER John P. Denny

ADDRESS 715 Light St

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SR9-1900

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55961

CERTIFICATE OF DEATH.

90 E 55961

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Aged Home ST. 27-54 WARD)

2-FULL NAME Mrs. Ella Scall

(a) RESIDENCE NO. Hebrew Home for Aged and Infirm ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Wolfe Scoll

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 76 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: old age
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Russia

PARENTS
10 NAME OF FATHER: [illegible]
11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia
12 MAIDEN NAME OF MOTHER: [illegible]
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Ella Kett
(Address) 701 N. Barrie St

15 Filed APR 9 - 1930, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1930, to 4-8, 1930,
that I last saw h.. alive on 4-8, 1930
and that death occurred, on the date stated above, at √ 30 P. m.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease
(duration) √ yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings

(Signed) H Edmund Levin M. D.
4/8, 1930 (Address) Levindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mahogany Road — DATE OF BURIAL 4/9 1930

20 UNDERTAKER: Jack Levin — ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M.

Spec. 1-30 M. A T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55962 ✓ E 55962

E 55962

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2331 Linden ave ST., 13-59 (WARD)

2-FULL NAME Bessie Levine

(a) RESIDENCE NO. 2331 Linden ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Levine

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	63	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Hamrit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Berkson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Levine

(Address) 2331 Linden ave

15 Filed 1930, 19 C. HAMPSON JONES, M. D. Registrar

PR9-1931

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9/30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1925, 19 ~, to April 8, 1930.

that I last saw her alive on April 8, 1930

and that death occurred, on the date stated above, at 1:40 9 m.

The CAUSE OF DEATH* was as follows:

Heart disease

(duration) 10 yrs. 3 mos ... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted, if not at place of death? Hosp

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sugar & symptoms

(Signed) M. Goldstein, M. D.

19 (Address) 2225 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Cemetery

DATE OF BURIAL 4/9 1930

UNDERTAKER Jack Louis

ADDRESS 1439 E Balt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 55963

CERTIFICATE OF DEATH

E 55963

REGISTERED NO.

1—PLACE OF DEATH S.W. Cor Belle Terrace and

CITY OF BALTIMORE: (No. Ellerslie aves ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Graham Reid

(a) RESIDENCE NO. Ellerslie ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos 8 ds. 22 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Reid

6 DATE OF BIRTH (month, day, and year) July 16 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Inverness Scotland

12 MAIDEN NAME OF MOTHER Margaret Inglis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Peterhead Scotland

14 Informant Arthur M. Reid

(Address) 502 Ellerslie Road

15 Filed 9-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7/30

17 I HEREBY CERTIFY, That I attended deceased from Feby 26 1930 to April 7 1930 that I last saw her alive on April 6 1930 and that death occurred, on the date stated above, at 4-20 a.m.

The CAUSE OF DEATH* was as follows:

Dry Gangrene - Left foot & leg -

(duration) 2 yrs. 2 mos. ✓ ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(duration) ✓ yrs ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) Wm. Pillsbury M. D.

4/8 1930 (Address) 415 Cedar Croft Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 9 1930
20 UNDERTAKER Chas. S. Black & Co.	ADDRESS 4 W. North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PRO

Spec. 130 M. & T.—250 Blks.

B 55964

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-00 B 55964

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 210 E. Lafayette St. (Hospital or Institution) 1949 (WARD)

2-FULL NAME Rosa J. Wirsing

(a) RESIDENCE NO. 210 E. Lafayette Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Herman F. Wirsing

6 DATE OF BIRTH (month, day, and year) March 7th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	1	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Maryland

PARENTS
10 NAME OF FATHER John P. Arnold
11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany
12 MAIDEN NAME OF MOTHER Sophia Dietz
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs. Catherine E. Arnold
(Address) 210 E. Lafayette Ave.

15 Filed ..... 19 ..... Registrar .....

R D - 1930

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1930

17 I HEREBY CERTIFY, That I attended deceased from mar 26, 1930, to apr 7, 1930, that I last saw h[e] alive on apr 7, 1930, and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac asthenia

(duration) ... yrs. about 10 days mos ... ds.

CONTRIBUTORY (Secondary) La Grip
(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? usual

(Signed) J. Roberts Ewell, M. D.
4/8, 1930 (Address) 2945 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 10 1930

20 UNDERTAKER Frederick L. Seabrooks & Fiddleton ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55965

CERTIFICATE OF DEATH.

E 55965

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joyle's Hosp ST. 9-17 WARD)

2-FULL NAME James Edward Simms

(a) RESIDENCE NO. 1 Glenarm 2nd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizbeth B. Simms

6 DATE OF BIRTH (month, day, and year) July 13 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Saw Mill

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland.

PARENTS

10 NAME OF FATHER Thomas T. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER Cordelia Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Maryland

14 Informant Elizabeth B. Simms

(Address) Glen Arm Md.

15 Filed . 19 Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7- 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-27 . 1930 to 4-7 . 1930 that I last saw him alive on 4-7 . 1930 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Transverse Myelitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? while at work

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Alfred Davis M. D.

. 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waugh Cemetery

DATE OF BURIAL April 30 1930

20 UNDERTAKER Frederick Lassahn

ADDRESS Sons Fullerton

APR 9 - 1930 C. HAMPSON JONES, M. D.

NRP

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION of DECEASED in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55966

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55966

CERTIFICATE OF DEATH.

REGISTERED NO. 99

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3510 Elliott St. 26-37 WARD)

2-FULL NAME Robert B. Hamrick

(a) RESIDENCE NO. 3510 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28/30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Noah Hamrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Addie Ridgley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Noah Hamrick

(Address) 3510 Elliott St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

R 9 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8/30

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 8, 1930, that I last saw him alive on April 8, 1930, and that death occurred, on the date stated above, at 8 15 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Respiratory collapse & diaphragmatic Spasm (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin data

(Signed) Leo Hellerstein, M. D.

, 19 (Address) 3834 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL April 10, 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Eden St

CAUSE OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dr. Campbell

Stock—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55962

CERTIFICATE OF DEATH.

100-001 E 55967.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 E. Barney St. 24-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Thos. Winterling

(a) Residence No. 109 E. Barney St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. 8 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 1st 1929

7-AGE. ..... yrs. 8 mos. 7 6 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER. Geo. A. Winterling

11-BIRTHPLACE OF FATHER (city or town) (State or Country). City

12-MAIDEN NAME OF MOTHER. Lillian Fowe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). City.

14- (Informant) Geo. A. Winterling

(Address) 109 E. Barney St.

15- Filed ..... 19..... No. .....

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 7 1930

17- I HEREBY CERTIFY, That I attended deceased from Apr. 5 1930 to Apr. 7 1930

that I last saw him alive on April 7 1930

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

4/8, 1930 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross C. A. Co

DATE OF BURIAL. April 9, 1930

20-UNDERTAKER. Margaret S. Flynn

ADDRESS 1417 Light St.

PRS - 1930

Print or write in ink. Fill in all blanks. Use ordinary abbreviations. Age should be stated in years, months and days. Cause of death must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55968

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55968

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 26-27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Kappell

(a) RESIDENCE NO. 306 S. Lehigh St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Barbara Kappell

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Works in mash room

(b) General nature of industry, business, or establishment in which employed (or employer) Yeast Co. 08

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Philip Kappell

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

R 9-1930 HH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-30

17 I HEREBY CERTIFY, That I attended deceased from 3-13-30, 19..., to 4-6-30, 19...,

that I last saw him alive on 4-6-30, 19...,

and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

(duration) yrs. 3 mos ... ds.

CONTRIBUTORY, (Secondary) Hypertension, Arteriosclerosis

(duration) yrs. 13 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean, M. D.

4-7, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL First Evan. Luth. Cemetery

DATE OF BURIAL april 10 1930

20 UNDERTAKER Lilly & Zeiler Bros.

ADDRESS 409 S. Wolfe St

Spec.—1-30—M. & T.—250 Blks.

E 55969 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55969

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 E. Clinton St. 126 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Kirby

(a) RESIDENCE NO. 1529 E. Clinton ST., 126 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Kirby.

6 DATE OF BIRTH (month, day, and year) Feb. 15 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER John W. Herman

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Katherine Huber

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Edna L. Kirby Husband (Address) 1529 E. Clinton St.

15 Filed ... 1930 ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1930 to April 5, 1930, that I last saw h[illegible] alive on April 5, 1930, and that death occurred, on the date stated above, at 6 15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum X ray etc

(Signed) N. J. Dashow M.D.

, 19 (Address) 3030 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	April 9th 1930
20 UNDERTAKER Lilly & Zeller Inc.	ADDRESS 4008 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55970 ✓ E 55970

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2609 Eastern Ave ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Rentschler

(a) RESIDENCE NO. 2609 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Marie Rentschler

6 DATE OF BIRTH (month, day, and year) Aug 3, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Martin Rentschler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Kunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna Rentschler

(Address) 2609 Eastern Ave

15 Filed APR 9 - 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1929, to April 8, 1930, that I last saw him alive on April 8, 1930, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kruger, M. D.

, 19 (Address) 2631 E Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL April 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eden

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 55971 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55971

CERTIFICATE OF DEATH.

REGISTERED NO. 26-36 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6601 Holabird Ave. Ward)

2-FULL NAME Mary L. Carl

(a) RESIDENCE NO. 6601 Holabird Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Carl

6 DATE OF BIRTH (month, day, and year) May 4-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Francis M. Frubinger

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Julia A. Gregg

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs Roland Seeger

(Address) 1011 N. Monroe St

15 Filed APR 9 - 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7-1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1930, to Apr 7, 1930, that I last saw her alive on Apr 7, 1930, and that death occurred, on the date stated above, at 10:15 P.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Failure

(duration) yrs. mos. 3 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. McCarmine M. D.

4/9/30 (Address) Woodedale, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Apr. 10 19 30

20 UNDERTAKER John Willett

ADDRESS 200 Fulton Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

E 55972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 55972

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Caroline (St.) (Ward) 26-38

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Smeller

(a) RESIDENCE NO. 1621 N. Bowley's Lane WARD
(Usual place of abode)
Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Smeller

6 DATE OF BIRTH (month, day, and year) July 10 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8	29	

8 OCCUPATION OF DECEASED Night Watchman

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Cleaning Works

(c) Name of employer 662

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER ? Smeller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Krueger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Augustus Langley
(Address) 1621 N. Bowley's Lane

15 Filed APR 9 1930 C. HAMPSON JONES, M. D. Registrar
By ARM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to April 9, 1930,
that I last saw him alive on April 9, 1930,
and that death occurred, on the date stated above, at 1.25 P.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-4-30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) V. Negrina, M. D.

. 19 (Address) St Josephs Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL April 12, 1930

20 UNDERTAKER John Allen Sr.

ADDRESS 2008 Eutaw

WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55973

CERTIFICATE OF DEATH

84 E 55973

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 N. Monroe ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sigmund Wormser

(a) RESIDENCE NO. 1714 N Monroe St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Wormser

6 DATE OF BIRTH (month, day, and year) Oct. 22, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. S. Wormser

(Address) 1714 N. Monroe St

15 Filed APR 9 - 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1930.

17 I HEREBY CERTIFY, That I attended deceased from ..., 1928, to April 8, 1930, that I last saw h[im] alive on April 8, 1930 and that death ocrurred, on the date stated above, at 8.45 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contrartrd if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor I. Levy M. D.

April, 1930 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 4/10/1930.

20 UNDERTAKER David Sondheim

ADDRESS 128-30 W. North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55074

CERTIFICATE OF DEATH

129 E 55074

27-47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 610 Springfielf Ave St. (Ward)

2-FULL NAME Mary E. Geraghty

(a) RESIDENCE NO. 610 Springfield Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Female	White	married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: J. Michael Geraghty

6 DATE OF BIRTH (month, day, and year): July 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Michael Reilly

11 BIRTHPLACE OF FATHER (city or town): (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Cahill

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Ireland

14 Informant (Address) Michael J. Geraghty 610 Springfield Ave

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

(Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 10, 1930
20 UNDERTAKER: John A. Moran	ADDRESS: 3000 E. Balto St.

Spec.—2-20-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55975

CERTIFICATE OF DEATH

100-01 E 55975

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 846 W Lombard ST.) (18-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony Ronald Adams

(a) RESIDENCE NO. 846 W Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 3/30.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	5 35	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Adams.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Helen Gibbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scranton Pennsylvania

14 Informant father (John Adams.
(Address) 846 W Lombard

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8/30

17 I HEREBY CERTIFY, That I attended deceased from Apr. 6 1930 to Apr 8 1930

that I last saw h[illegible] alive on Apr 6, 1930 6 pm

and that death occurred, on the date stated above, at 6 pm.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings

(Signed) J. H. MacMyler M. D.

, 19 (Address) 846 W Lombard.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 19 30
20 UNDERTAKER John [illegible]	ADDRESS 423 S Paca St

BEFORE signing, be certain that all items have been properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55976 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55976

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hosp. REGISTERED NO. 10109

CITY OF BALTIMORE: (No. 22-30 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Newkirk

(a) RESIDENCE NO. 614 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER Edw. Newkirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed APR 9 1930 Rem Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-3-30

17 I HEREBY CERTIFY, That I attended deceased from 3-31-30, 19 , to 4-3-30, 19 ,

that I last saw him alive on 4-3-30, 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. McLean M. D.

4-4, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19
20 UNDERTAKER	ADDRESS
C. T. JOHNSTONE, JR.	

APR 9 1930

APR 5 - 1930

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

23 L 35977 Md. — L 55977 — 100-006

1—PLACE OF DEATH: JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ____ ST. 4-7 (WARD)

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Shangford

(a) RESIDENCE NO. 629 S Paca ST., WARD ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ____

6 DATE OF BIRTH (month, day, and year) ____

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ____ 070

(c) Name of employer ____

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 4-5-30 19 Reid Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-30

17 I HEREBY CERTIFY, That I attended deceased from 2-21, 1930 to 4-1, 1930, that I last saw h[illegible] alive on 4-1, 1930 and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ____ yrs. ____ mos. 8 ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of ____

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical findings

(Signed) Hedwig Kovacs, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL ____ 19

20 UNDERTAKER Commissioner Health — ADDRESS ____

APR 5 - 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 55978

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55978

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1407 N. Gay ST. 8 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline A. Pasterfield

(a) RESIDENCE NO. 1407 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 10 mos. \ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) the late Charles L. Pasterfield

6 DATE OF BIRTH (month, day, and year) June 9 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frederick Pasterfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Unger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. Pasterfield

(Address) 1407 N. Gay St.

15 Filed APR 9 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 5 1929 to April 9 1930

that I last saw he alive on April 8 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Lee M. D.

4/9 1930 (Address) 413 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Apr. 12 1930
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons, Inc.	1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S 55979 F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 55979

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Provident Hospital ST. 14-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Cox

(a) RESIDENCE NO. 2223 Pennsylvania Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	married

5a If married, widowed, or divorced RUSBAND of (or) WIFE of Margaretta Cox

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) 610

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Mary Stewart.

(Address) 812 N. Calhoun St

15 Filed APR 9 1930, 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7-30

17 I HEREBY CERTIFY, That I attended deceased (from March 21, 1930, to April 7, 1930, that I last saw h— alive on April 7, 1930 and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X-ray

(Signed) Carroll M St Clair, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	4/10 1930
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1303 Pennsylvania Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 55980 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55980

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ~~1413 Mount~~ ST. 15-21 WARD)

2-FULL NAME Isabel Tasker

(a) RESIDENCE NO. 1413 Mount ST. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. dt.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John W. Tasker.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Lena Gough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant (Address) John W. Tasker 1413 N. mount St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1930, to 4/7, 1930.

that I last saw h[illegible] alive on 4/7, 1930,

and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows:

Br. Antiparlum Types

Broncho Pneumonia

(duration) yrs. mos ds

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes Laboratory

What test confirmed diagnosis? Pneumococcus

(Signed) Abram S. Winter, M. D.

, 19 (Address) Rosewood Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL 4/11 1930

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pennsylvania Ave

MAGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55981

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals (16-22 WARD)

CITY OF BALTIMORE: (No. ..... ST.

2-FULL NAME Samuel Dorsey

(a) RESIDENCE NO. 712 N. Mount ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 4, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm work

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henson Dorsey

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ariel Blackston

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-30

17 I HEREBY CERTIFY, That I attended deceased from 2-27-30, 19..., to 4-8-30, 19...,

that I last saw him alive on 4-8-30, 19...,

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ner. yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Cirrhosis ?
Disease of Bones (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical: X-ray

(Signed) Marvin H. McLean, M. D.

4-9, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 4/10 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 55982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 55982

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen. Hosp ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Louise Miller

(a) RESIDENCE NO. 4126 Forest Park Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible] E Miller

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore Md.

PARENTS

10 NAME OF FATHER Elijah E Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Spencer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hosp. Records

(Address)

15 Filed APR 9 1930 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7-30 19

17 I HEREBY CERTIFY, That I attended deceased from 3-25-30, 19, to 4-7-30, 19,

that I last saw h[illegible] alive on 4-7-30, 19,

and that death occurred, on the date stated above, at 8:50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Cardio-renal disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Congestive Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

4 (Signed) Thos A Jamison M. D.

19 30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 10 1930
20 UNDERTAKER	ADDRESS
Fortmann & Lore	123 N Lafayette Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55983 HEALTH DEPARTMENT—CITY OF BALTIMORE E 55983

CERTIFICATE OF DEATH.

84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2532 E. Balto. ST. 6610 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Fischer

(a) RESIDENCE NO. 2532 E. Balto. ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline L. Fischer

6 DATE OF BIRTH (month, day, and year) Jan. 25th 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Ind

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John F. Fischer

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Caroline L. Fischer (Address) 2532 E. Balto. Md

15 Filed ..... 19.. Registrar

R [illegible] 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1930

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 7, 1930, that I last saw him alive on April 7, 1930, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (Ver)

(duration) 1 yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Penn 2nd, M. D.

4. 8. 1930 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL April 8 1930

20 UNDERTAKER Lilly & Zeiler (inc) ADDRESS 403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55984

CERTIFICATE OF DEATH

51 E 55984

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1336 Hollins ST., 14-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marian Hulse

(a) RESIDENCE NO. 1336 Hollins ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of School Girl

6 DATE OF BIRTH (month, day, and year) Nov 16 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chicago

PARENTS

10 NAME OF FATHER Julian Hulse

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Johanna May

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Julian Hulse

(Address) 1336 Hollins St

15 Filed ..., 19... Registrar RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 3, 1930, to Apr 8, 1930, that I last saw her alive on Apr 8, 1930 and that death occurred, on the date stated above, at 1:45 P m.

The CAUSE OF DEATH* was as follows:

Rheumatism of Heart.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Grippe 5 mos ago. (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M Bowman Lloyd, M. D.

4/9, 1930 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park	April 10 1930
20 UNDERTAKER	ADDRESS
Chinoweth & Son	345 Edmondson Ave

mation should be carefully supplied. ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

E 55985

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55985

CERTIFICATE OF DEATH

47

1—PLACE OF DEATH

REGISTERED NO. 13751

CITY OF BALTIMORE: (No.) University Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Crue

(a) RESIDENCE NO. 2940 Keswick Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Crue

6 DATE OF BIRTH (month, day, and year) April 21, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Curtis Benjamin

(Address) 2940 Keswick Road.

15 Filed APR 9 - 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8-1930

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to April 8, 1930, that I last saw her alive on April 8, 1930 and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Right Breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/7/30

Was there an autopsy? No

What test confirmed diagnosis? Hist. P.E. Clin Signs & Symptoms

(Signed) W. Glenn Speicher M. D.

4/8, 1930 (Address) University Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hampden	April 11, 1930
20 UNDERTAKER	ADDRESS
Thanhouser Son	3615 Chestnut Ave

mation should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Zinberg 2320 Eutaw Place ✓ Lafayette 4822

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55986

CERTIFICATE OF DEATH.

74-001

E 55986

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 Whitelock ST. 13-59 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Wright Tatum

(a) RESIDENCE NO. 811 Whitelock ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carey P. Tatum

6 DATE OF BIRTH (month, day, and year) 10/23/1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Delaware

PARENTS

10 NAME OF FATHER John W. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Hattie Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Carey P. Tatum

(Address) 811 Whitelock st

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/30

17 I HEREBY CERTIFY, That I attended deceased from 4/7, 1930, to 4/8, 1930,

that I last saw her alive on 4/7, 1930,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) H Zinberg, M. D.

4/8, 1930 (Address) 2320 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Seaford Del

DATE OF BURIAL 4/10 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 9 1930 C. H. JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55987

CERTIFICATE OF DEATH.

90 E 55987

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5200- Maple Ave (St.) 7-55 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. McNeir

(a) RESIDENCE NO. 5200- Maple Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew S. McNeir

6 DATE OF BIRTH (month, day, and year) 11-22-1862

7 AGE Years	Months	Days	If LESS than 1 day ...hrs. or ...min.
67	4	15 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER County Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Melvale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Marshall McNeir 5200- Maple Ave

15 Filed APR 10 1930, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1930, to Apr 7, 1930,

that I last saw h[illegible] alive on Apr 7, 1930,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Leonard J Wells, M. D.

, 19 (Address) 1274 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 4/10/30

20 UNDERTAKER Mary T. Puth

ADDRESS 1235 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 55988

E 55988

1—PLACE OF DEATH

REGISTERED NO. 30-18

CITY OF BALTIMORE: (No. 1916 Wilkens Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane LaRue Bean

(a) RESIDENCE NO. 1916 Wilkens ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/ yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married,~~ Widowed, or ~~Divorced~~ (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5 - 1929

7 AGE: Years | Months 8 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Benj F Bean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Cash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Benj F Bean

(Address) 1916 Wilkens ave.

15 Filed 4-11 1930 C. RAYMOND JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9/30

17 I HEREBY CERTIFY, That I attended deceased from 4/5/ 1930, to 4/9 1930,

that I last saw h alive on 4/9 1930

and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

19 (Address) 2030 Wilkens ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkridge M E Cem

DATE OF BURIAL: 4/10 1930

20 UNDERTAKER: Robert Brooksbank

ADDRESS: Baltimore Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Abrams 2360 Eaton Place

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55989

CERTIFICATE OF DEATH.

84 E 55989

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3823 Barrington Rd (St.) 55-63 (Ward)

2-FULL NAME Nicholas M Mathews

(a) RESIDENCE No. 3823 Barrington Road St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Bessie L Matthews

6 DATE OF BIRTH (month, day, and year) June 16 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER Thos H Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgetown D C

12 MAIDEN NAME OF MOTHER Rebecca J Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bessie L Matthews (Address) 217 E Saratoga St

15 Filed APR 10 1930 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 27 1930, to Apr 8 1930,

that I last saw h.. alive on Jan 8 1930,

and that death occurred, on the date stated above, at 3:50 p.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia Uremic Poisoning

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Richard H Abrams, M. D.

April 9, 1930 (Address) 2360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL April 10 1930

20 UNDERTAKER Wm Cook — ADDRESS 1317 E Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Norton 588 N Lombard St

E 55990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 V E 55990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1146 N. Homburg ST. 21-29 WARD)

2-FULL NAME Joseph Leonard Schmelz

(a) RESIDENCE NO. 1146 N. Homburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schmelz

6 DATE OF BIRTH (month, day, and year) Nov 21, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Elgin Bros

9 BIRTHPLACE (City or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Schmelz

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

14 Informant Elizabeth Schmelz

(Address) 1146 Homburg St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9, 1930

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1929 to Apr. 9, 1930,

that I last saw him alive on Apr. 9, 1930,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Findings & X Ray.

(Signed) Theodore Jones, M. D.

4/9, 1930 (Address) 855 N Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 4 12 1930

20 UNDERTAKER Jno Cook

ADDRESS 1217 E Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Ruzicka

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55991

CERTIFICATE OF DEATH.

38 E 55991

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 N. Washington ST. 6 WARD)

2-FULL NAME Mary E Piscano

(a) RESIDENCE NO. 137 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Salvatore Piscano

6 DATE OF BIRTH (month, day, and year) Dec 5, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER Louis Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Sharpe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Salvatore Piscano (Address) 137 N Washington St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5. 1938

17 I HEREBY CERTIFY, That I attended deceased from 1928, 19 30 to April 5, 19 38, that I last saw h alive on April 5, 19 38, and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Ca Pancreas

Cerebral Hemorrhage

only 1 day

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Weltmer M. D.

(Address) 600 N Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 4/11 1938

20 UNDERTAKER J. W. Cook

ADDRESS 1217 E Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 55992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 55992

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 Division ST. 4-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Bailey

(a) RESIDENCE NO. 2010 Division ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Bailey

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Pro. 86

(b) General nature of industry, business, or establishment in which employed (or employer) J Boot black Polar

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac. Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah E. Bailey

(Address) 2010 Division St

15 Filed APR 10 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7/1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1929, to April 7, 1930.

that I last saw him alive on April 6, 1930

and that death occurred, on the date stated above, at 5.15 A m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. L. McCard M. D.

4/9, 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 4-10 1930

20 UNDERTAKER: Jno. H. Joachim

ADDRESS 1027 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55993

CERTIFICATE OF DEATH.

161-001 E 55993

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 11 E. Barney St. 2334 Ward)

2-FULL NAME Twin #1 of Mr. & Mrs. Wm E. Walter

(a) RESIDENCE NO. 11 E. Barney St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 3, 1930

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) not

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Wm E. Walter

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Helen V. Reese

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

14 Informant William E. Walter

(Address) 11 E. Barney St.

15 Filed ..... 19 ..... G. HAMPSON JONES, M. D. Registrar

By: R.M.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1930 19

17 I HEREBY CERTIFY, That I attended deceased from April 3 19 30 to April 9 19 30, that I last saw him alive on April 9 19 30, and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. C. Campbell, M. D.

4/9, 1930 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Date of Burial 4/10 1930

20 UNDERTAKER Jos Joerdens Son ADDRESS 2178 Pa

APR 10 1930

don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 55994

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55994

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 N East Ave ST. 76-11 WARD)

2-FULL NAME Charles C. Freeman

(a) RESIDENCE NO. 1 N East Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Freeman

6 DATE OF BIRTH (month, day, and year) Aug 2-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	90	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Collector

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Freeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John Freeman (Address) 1 N East Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8-1930

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1930, to April 8, 1930, that I last saw h[illegible] alive on April 8, 1930 and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows: Epidermitis of Right Ear

Acute Pulsation Ordered

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. L. Sudler, M. D.

4/9, 1930 (Address) 3323 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL April 1930

20 UNDERTAKER John Ulrich

ADDRESS 2008 Aliceanna

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 55995

E 55995

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1432 E. Monument St. 16-13 Ward)

2-FULL NAME Nick Tolson

(a) RESIDENCE NO. 1432 E. Monument St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) H
(State or country)

12 MAIDEN NAME OF MOTHER H

13 BIRTHPLACE OF MOTHER (city or town) H
(State or country)

14 Informant John W. Henderson
(Address) 1502 E. Monument St

15 Filed APR 14 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Insufficiency

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis-Senility

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. Kuhns M. D.

4/9/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion

DATE OF BURIAL April 10 1930

20 UNDERTAKER John W Henderson

ADDRESS 1502 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 55996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

E 55996

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1011 W. 36th St ST. 18-29 WARD

2-FULL NAME Lena Sondell

(a) RESIDENCE No. 128 S. Appleton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Sondell

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Block

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [redacted]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob Steinberg (Address) 1011 W. 36th St

15 Filed APR 7 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/30

17 I HEREBY CERTIFY, That I attended deceased from 4-6 1930 to 4-10 1930

that I last saw her alive on 4-10 1930

and that death occurred, on the date stated above, at 7.9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Congestion

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Gen Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. F. Curtain, M. D.

4/14 1930 (Address) 370 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mosh Rd

DATE OF BURIAL 4/10 1930

20 UNDERTAKER Jack Lewis

ADDRESS 1429 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. mation CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55997

CERTIFICATE OF DEATH.

129 E 55997

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1722 N. Pulaski St. 15-66 WARD)

2-FULL NAME Abraham Wolfe

(a) RESIDENCE NO. 1722 N. Pulaski St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary 038

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Isaac Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Goodman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Isaac Wolfe
(Address) 1722 N Pulaski St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 4, 1930, to April 9th, 1930,

that I last saw h[illegible] alive on April 9th, 1930,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic diffused Nephritis

Chr. Myocardial Insufficiency (duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Coronary thrombosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) M. A. Nicholson, M. D.

April 9th 1930 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 4/10 1930

20 UNDERTAKER Jack Levin

ADDRESS 1439 E Baltimore St

Spec.—8-16-29—L. F. S.—100 Bks.

E 55998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 1 V E 55998

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital Baltimore, Md. ST. 22-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Willie James

(a) RESIDENCE NO. 127 Hill St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Fireman

(c) Name of employer SS Yorktown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Leonard James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Henrietta ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records, U.S. Marine Hospital

(Address) Baltimore, Md.

15 Filed ..., 19... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from February 24, 19 30, to April 7, 19 30, that I last saw him alive on April 7, 19 30 and that death occurred, on the date stated above, at 7:30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, active

unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? clinical & lab. findings

(Signed) Ralph L Porter, M. D.

4/7, 19 30 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	April 10, 19 30
20 UNDERTAKER	ADDRESS
E. LeRoy Stuffle, Inc	1256 N. Monroe Ave

information should be carefully supplied. All questions should be answered. CAUSE OF DEATH in plain terms. Indefinite and improper classification of OCCUPATION is very important. See instructions on back of certificates.

APR 16 1930

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 55999

CERTIFICATE OF DEATH.

7V E 55999

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2314 Fleet St. St. 13 Ward)

2-FULL NAME John Bulkowski

(a) RESIDENCE NO. 2314 Fleet St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25 1929

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) _____

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Bulkowski

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Gnerive Dmytrow

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Baltimore Md.

14 Informant John Bulkowski

(Address) 2314 Fleet St.

15 Filed APR 10 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Measles

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) ___ yrs. ___ mos. ___ ds.

4/10/30 G C Slades M. D.

(Coroner)

19 (Address) 1436 Bury

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Date of Burial April 10 1930

20 UNDERTAKER John W Welder ADDRESS 401-2 Chester Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of data should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56000 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 56000

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5102 Eugene Ave ST. 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine L. Bartley

(a) RESIDENCE NO. 5102 Eugene Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry D. Bartley

6 DATE OF BIRTH (month, day, and year) April 7-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	25	-	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Daniels Reeves

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Katharine Long.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Katherine Reeves

(Address) 5102 Eugene ave

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 19. 1929 to April 9. 1930, that I last saw her alive on April 8th. 1930, and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

History given

Estimated given (duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

13 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam. X Ray

(Signed) David W. Jones M. D.

4/10/, 1930 (Address) 1011 N. Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL April 12 19 30

20 UNDERTAKER George W. Zirkler

ADDRESS 1797 E. Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... OCCUPATION is very important. See instructions on back of certificates.

APR 10 1930 C. [illegible] M. [illegible]

per.—7-17-26 A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001
56001

56001 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 Pa ave St. 17-26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Geller

(a) RESIDENCE NO. 503 Pa ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Geller

6 DATE OF BIRTH (month, day, and year) Aug 17-59

7 AGE	Years	Months	Days
	70	7	6

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Kuhn

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Elizabeth Geller

(Address) 503 Pa ave

15 Filed 19 Reg

N. B.—WRITE PLAINLY, with ink. All questions should be carefully supplied. Accuracy of DEATH in plain terms, so that it may be very important. See instructions on back of

APR 10 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1929 to April 8, 1930, that I last saw her alive on April 8, 1930, and that death occurred, on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman

April 9 1930 (Address) 2681 Mad

*State the Disease Causing Death, or in deaths from Violence state (1) Means and Nature of Injury, and (2) Whether Suicidal, or Homicidal. (See reverse side for additional space.

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Apr

20 UNDERTAKER W Murkerton ADDRESS 230 Gre

Spec.—1-12-23—M&T—500 Blks.

E 56002

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56002

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3619 Belvedere ST. 27-55 WARD)

2-FULL NAME Donald Charles Tracey

(a) RESIDENCE NO. 3619 Belvedere ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 22-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Charles Howard Tracy

11 BIRTHPLACE OF FATHER (city or town) Balt (State or country) Md

12 MAIDEN NAME OF MOTHER Elsie B. Coffee

13 BIRTHPLACE OF MOTHER (city or town) Balt (State or country) Md

14 Informant Aunt Mrs. Raymond
(Address) 3619 Belvedere

15 Filed APR 10 1930 W. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/3, 1930, to 4/7, 1930, that I last saw him alive on 4/7, 1930 and that death occurred, on the date stated above, at 5 A.M. 4/10/30

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. A. Spirit, M. D.

, 19 (Address) 704 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery

DATE OF BURIAL April 12 1930

20 UNDERTAKER W. M. Coulson

ADDRESS 1223 N Howard St

CAUSE OF DEATH to be filled in by physician. See instructions on back of certificates. TION is very important

H. HAMILTON JONES, M.D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56003

CERTIFICATE OF DEATH.

40 E 56003

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Biltmore Hotel St. 20-27 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George S. Lang.

(a) RESIDENCE NO. 1948 Mulberry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clara. A Lang

6 DATE OF BIRTH (month, day, and year): March 10 1869

7 AGE — Years: 61 Months: 0 Days: 30 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horse Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): at

(c) Name of employer: Biltmore Hotel

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Lang.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Emma. Hagen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Clara. A Lang.

(Address) 1948. Mulberry St.

15 Filed: 4-11 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-9 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Eugene Feller M. D.

(Coroner)

4/11, 1930. (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park. Date of Burial: 4-11 1930

20 UNDERTAKER: Mrs Chas A G Rohde ADDRESS: 2327 Edmondson Ave

APR 11 1930 HARRISON JONES, M. D.

OF DEATH is plain and very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56004

CERTIFICATE OF DEATH

47 ✓ E 56004

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2770 Alameda Blvd (ST.) 9-46 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta R Ruff.

(a) RESIDENCE NO. 2770 Alameda Blvd. ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Ruff

6 DATE OF BIRTH (month, day, and year): July 10th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Marie Preston.

(Address) 1032 E Fort Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-7-30

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1929 to Apr 7, 1930 that I last saw h.. alive on Apr 7, 1930 and that death occurred, on the date stated above, at 6 50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

1 Stage

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 15/1928

Was there an autopsy? no

What test confirmed diagnosis? X Ray Physical Exam

(Signed) J Mark Thomas M. D.

(Address) 1228 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A&C	4-11th 1930
20 UNDERTAKER	ADDRESS
E & B Hasle	115 E Mt St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56005

10-001

E 56005

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Sydenham Hospital ST. 18-7a WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis J Jasper Jr

(a) RESIDENCE NO. 1203 Edmondson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	1	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis J. Jasper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Lorretta Hickey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Louis J Jasper

(Address) 1203 Edmondson ave

15 Filed APR 10 1930 19 ___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 5 1930, to April 9 1930, that I last saw h[illegible] alive on April 9 1930 and that death occurred, on the date stated above, at 2 35 p m.

The CAUSE OF DEATH* was as follows:

Laryngeal Diphtheria

(duration) yrs. mos. 4 8 ds.

CONTRIBUTORY (Secondary) Secondary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Tracheotomy Date of 4-1-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + pos. culture

(Signed) Myron G Tull, M. D.

4/10, 1930 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bells Cemetery	April 10 1930
20 UNDERTAKER	ADDRESS
J B Tippett	855 W Balto St

Important. See instructions on back of certificate.

Spec.—6-16-29—L. F. S.—100 Bks.

✓ E 56006

E 56006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2427 E. Monument ST., 7-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stella M Hines

(a) RESIDENCE NO. 2427 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mr. Edward J Hines

6 DATE OF BIRTH (month, day, and year) Aug. 28 18[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa

PARENTS

10 NAME OF FATHER Israel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Ethel Hemmingshouse

(Address) 2414 E Monument St

15 Filed [illegible] 19 C. H. JAMESON JONES, M. D. Registrar

APR 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-30

17 I HEREBY CERTIFY, That I attended deceased (from Jan. 27 April 8, 1930, that I last saw her alive on April 8, 1930 and that death occurred, on the date stated above, at 3.30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1927

Was there an autopsy?

What test confirmed diagnosis? Microscope

(Signed) Louis Krause, M. D.

19 (Address) Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 10, 30
20 UNDERTAKER	ADDRESS
Russ & Miller & Son	2334 Jeffers

Fill in the items above carefully and correctly. All are important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56007 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56007

CERTIFICATE OF DEATH

159-003

1—PLACE OF DEATH Hospital for Women of Md. REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Christopher Thomas

(a) RESIDENCE NO. Hosp. for Women of Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life da. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-25-30

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry B. Thomas

11 BIRTHPLACE OF FATHER (city or town) California
(State or country)

12 MAIDEN NAME OF MOTHER Camilla E. Hall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Henry Bernard Thomas
(Address) Arnolds School- Severna Park Md

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/30

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1930, to April 4, 1930.

that I last saw h[illegible] alive on April 3, 1930

and that death occurred, on the date stated above, at 7.00 p. m.

The CAUSE OF DEATH* was as follows:

Pylonic Stenosis

(duration) Life mos. ds.

CONTRIBUTORY (Secondary) Capillary hemangioma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Earle C. Wilson, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fellowcraft Cem	April 11 1930
20 UNDERTAKER	ADDRESS
Henry Jenkins & Son	Eldwood & Nicholson

Important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56008 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56008

91-002

CERTIFICATE OF DEATH.

REGISTERED NO. 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2730 N. Charles St ST. 12 WARD)

2-FULL NAME John Blackford Van Meter

(a) RESIDENCE NO. 2730 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lucinda Cannell (Van Meter)

6 DATE OF BIRTH (month, day, and year) Sept 6, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Educator and clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Thomas Hurley Van Meter

11 BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Johnnetta Blackford

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or country) Pennsylvania

14 Informant Johnnetta Van Meter
(Address) 2730 N. Charles Street

15 Filed APR 3 1930 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1930

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to April 8, 1930, that I last saw him alive on April 8, 1930, and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (Senility)

(duration) Some yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. M. Fuller M. D.

4/9, 1930 (Address) 6435 Mary Center.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL April 11 1930

20 UNDERTAKER Henry Watkins Sons Co

ADDRESS McCulloh & Orchard Sts

TION is very important See instructions on back of certificate

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56009

CERTIFICATE OF DEATH

E 56009

100-001

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 St Mary St., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME May A. Hall

(a) RESIDENCE NO. 520 St Mary ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hall

6 DATE OF BIRTH (month, day, and year): Feb 9, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	34	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife, 037

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto md.

PARENTS

10 NAME OF FATHER: Walker Thompson.

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Annie S. Hall.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Annie Strippiant

(Address): 520 St mary St.

15 Filed ... 19 ... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 8-1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 4 1930 to Apr 8 1930

that I last saw h[illegible] alive on Apr 7 1930

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Br. pneumonia

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary): None known

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Chas. J. Keller, M. D.

4/10 1930 (Address) 2226 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bonnie Brea cemetery

DATE OF BURIAL: 4/11 1930

20 UNDERTAKER: John M. Johnson.

ADDRESS: 2338 Madison ave

Fill in all the points called for in this certificate. See instructions on back of certificate. It is important.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56019

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 56010

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Bowman

(a) RESIDENCE NO. 1112 E Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Aron Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ruth Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 10 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8-1930

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 8, 1930, that I last saw h.r alive on April 8, 1930 and that death occurred, on the date stated above, at 1 35 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bac

(Signed) Abraham Preston M. D.

4/10. 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D. C.	April 10 1930
20 UNDERTAKER Laurence F. Kemsley	ADDRESS Md Ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56011 ✓ 44 E 56011

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2110 Aliceanna ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME WALENTY CLAPINSKI,

(a) RESIDENCE NO. 2110 Aliceanna ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Magolezata Clapinski,

6 DATE OF BIRTH (month, day, and year) Febr., --1860.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer, 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pozan,
(State or country) Poland,

PARENTS

10 NAME OF FATHER Stanislaus Clapinski,

11 BIRTHPLACE OF FATHER (city or town) Pozan,
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown,

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Mrs. M. Clapinski, (Wife)
(Address) 2110 Aliceanna Street

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apriel 8-1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 19 29, to April 8, 19 30.

that I last saw h.m alive on April 8, 19 30

and that death occurred, on the date stated above, at 3.00 P.m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Frank H. Jackson, M. D.

19 (Address) 2701 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
H. of Stanislaus,	Apr. 12. 1930.
20 UNDERTAKER	ADDRESS
W. F. Sadrowski Co.,	2715 Pelham Ave

important. See instructions on back of certificate.

APR 10 1930

Spec.—1-30—M. & T.—250 Bks.

E 56012 HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 56012

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto. City Hospitals

CITY OF BALTIMORE: (No. ST. 5-8 WARD)

2-FULL NAME Lottie Thompson

(a) RESIDENCE NO. 1119 McEldery St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Thompson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
31	?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Chas. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliza Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed ....., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-30

17 I HEREBY CERTIFY, That I attended deceased from 3-21-30, 19..., to 4-5-30, 19...,

that I last saw her alive on 4-5-30, 19...,

and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis, tertiary

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Syphilitic Myelitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical W.R.

(Signed) Warwin W. McLaw, M. D.

4-8, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Comissioner Health

ADDRESS

UNIVERSITY OF MARYLAND APR 10 1930

1530 Rec'd

— TION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56013

CERTIFICATE OF DEATH.

E 56013

1-PLACE OF DEATH St Joseph Hospital REGISTERED NO.

CITY OF BALTIMORE: (No.) 6 Caroline ave St. 10-11 Ward, (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby boy Dorsey

(a) RESIDENCE NO. 1202 Chilcoat ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wh	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 4-4-30.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			5 Hours	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address)

15 Filed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8 1930.

17 I HEREBY CERTIFY, That I attended deceased from 4-7-30, 19 , to 4-8-30, 19 , that I last saw h— alive on 4-8-30, 19 , and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis

5 Hours

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Congenital Pneumonia

(duration) yrs. mos ds.

18 Where was disease contracted, if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Wm Hamilton Jones M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL 19

20 UNDERTAKER ADDRESS

APR 10 1930 WM. HAMILTON JONES, M. D. APR 10 1930

Commissioner Health.

REFER HOME TO PHYSICIAN. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

E 56014

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3707 Overview Rd (Street) (WARD)

2-FULL NAME Anna Satisky

(a) RESIDENCE No. 3707 Overview Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Israel Satisky

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Bernard M. Greber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Kelesen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Israel Satisky

(Address) 3707 Overview Road

15 Filed APR 10 1930 19 Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9/30

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1930, to April-9- 1930, that I last saw her alive on April-9- 1930, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis about 8 yrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X ray, sputum

(Signed) Herman Sindel M. D.

4/10 1930 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodeph Shalom — DATE OF BURIAL 4/10 1930

20 UNDERTAKER Jack Loubs 1439 E Balto St — ADDRESS

CAUSE OF DEATH. See instructions on back of certificates. TION is very important

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56015

E 56015

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen Hosp SE. 16-64 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Kelley

(a) RESIDENCE NO. Turner's Station ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos 6 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucy Kelley

6 DATE OF BIRTH (month, day, and year) Mar 5 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	38	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Old Point Comfort Va

PARENTS

10 NAME OF FATHER Abel Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lucy Kelley
(Address) Turners Station Md.

15 Filed APR 16 1930, 19 R.V.C. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. BE SURE TO FILL IN ALL ITEMS. DEATH is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9 1930

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1930, to April 9, 1930, that I last saw h alive on April 9, 1930, and that death occurred, on the date stated above, at 415 P. M.

The CAUSE OF DEATH* was as follows:

Influenza bronchopneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) S. A. Hagan, M. D.

, 19 (Address) West Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Point Comfort Va

DATE OF BURIAL April 9 1930

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1765 Madison Ave

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56016

CERTIFICATE OF DEATH

90 E 56016

REGISTERED NO. 16-67

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Ellamont ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Lee Taylor,

(a) RESIDENCE NO. 1406 Ellamont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Sadie S. Taylor,

6 DATE OF BIRTH (month, day, and year) October 13. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer Sherwood Oil Co.

9 BIRTHPLACE (city or town) (State or country) Harrisonburg Va.

PARENTS

10 NAME OF FATHER Harvey Taylor,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Barbara Gaither,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Mrs. Sadie S. Taylor

(Address) 1406 Ellamont St

Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 9- 1930

17 I HEREBY CERTIFY, That I attended deceased from June 5th 1929, to April 8th 1930, that I last saw h~~e~~ alive on April 8th 1930 and that death occurred, on the date stated above, at 10 00 A m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular disease of Hyo Cardium.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Richard O. Thomas, M. D.

Apr 9, 1930 (Address) 2360 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL APR 11 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

important. See instructions on back of certificate.

Spec—12-24-21—E.B.R.S.—400 Pds.

E 56017 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56017

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 523 W. Barre St. 27-3 (or 161-3) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Reddick

(a) Residence No. 523 W. Barre St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): April 7, 1930

7-AGE: ....yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: 0d

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md.

PARENTS.

10-NAME OF FATHER: Mavin Reddick

11-BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina

12-MAIDEN NAME OF MOTHER: Pauline Miller

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): North Carolina

11-(Informant):

(Address):

15-Filed 1 0 1930 C. HAMPSON JONES, M. D. Registrar.

4534

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 4-9-30

17- I HEREBY CERTIFY, That I attended deceased from April 7, 1930 to April 9 1930

that I last saw him alive on 4-9 1930

and that death occurred, on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity. (26 weeks).

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis H. Kemp Jones M D

4/10 1930 (Address) Univ. Hosp.

*State the Disease Causing Death, or If deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL. APR 10 1930 19...

20-UNDERTAKER: Commissioner Health

ADDRESS

In plain terms, so that it may be properly examined. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56018 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56918

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 18-26 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Jessup

(a) RESIDENCE NO. 921 W. Saratoga ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
unknown, 56 or 60 ? about ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Jessup

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed ..... 1930 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7-30

17 I HEREBY CERTIFY, That I attended deceased from 4-1-30, 19..., to 4-7-30, 19..., that I last saw him alive on 4-7-30, 19..., and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos 13 ds.

CONTRIBUTORY (Secondary) Syphilis, tertiary ?

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical W.R.

(Signed) Warren H. McLean, M. D.

4-8, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 11, 1930
20 UNDERTAKER	ADDRESS
Mrs. Lottie R. Williams	372 Schroeder St

TION is very important See instructions on

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56019

CERTIFICATE OF DEATH

101-001 ✓ E 56019

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1800 Kossthuen ST. (Prestman) 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Lewis Anston

(a) RESIDENCE NO. 1800 Kossthuen ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): married

6 DATE OF BIRTH (month, day, and year): year 1885

7 AGE: Years 45 (44) Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Petersburg, Va

PARENTS

10 NAME OF FATHER: Levy Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Petersburg Va

12 MAIDEN NAME OF MOTHER: Rosa Duncan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Petersburg Va

14 Informant: Estelle Moore

(Address): 1800 Prestman St

15 Filed ..... 19 ..... Registrar

ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1930

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 9, 1930, that I last saw h[illegible] alive on April 9, 1930 and that death occurred, on the date stated above, at 1150 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Petersburg, Va	April 10, 1930
20 UNDERTAKER	ADDRESS
Mrs. Katie R. Williams	327 Sycamore St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

135 E 56020

1—PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James B. Macneal

(a) RESIDENCE NO. 2624 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Sylvester Macneal

6 DATE OF BIRTH (month, day, and year): Nov. 28, 1841

7 AGE: Years 88 yrs. | Months 4 | Days 12 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): ~~Cats~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Andrew L. Macneal

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Maryland

12 MAIDEN NAME OF MOTHER: Monica Ann Nedler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Maryland

14 Informant: Hospital Records.

(Address)

15 Filed ___, 19___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10/30

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1930, to April 10, 1930, that I last saw h im alive on April 9, 1930 and that death occurred, on the date stated above, at 5:55 a.m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of the prostate, benign

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Jan 16, 1930

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) M. L. Brosius, M. D.

4/10/1930 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Apr. 12 1930

20 UNDERTAKER: [illegible] Cook

ADDRESS: 1003 West Baltimore St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56021

CERTIFICATE OF DEATH

49 E 56021

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2125 Annapolis Ave. ST. 25-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry L. Philipp

(a) RESIDENCE NO. 2125 Annapolis Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lottie Philipp

6 DATE OF BIRTH (month, day, and year) April 27, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	11	13	

8 OCCUPATION OF DECEASER

(a) Trade, profession or particular kind of work Furniture Packer

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Philipp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Lottie Philipp

(Address) 2125 Annapolis Ave.

15 Filed APR 10 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to April 9, 1930, that I last saw him alive on April 4, 1930 and that death occurred, on the date stated above, at 3.25 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder (Secondary)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General metastasis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. H. Frick, M. D.

April 12, 1930 (Address) 936 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr. 11 19 30

20 UNDERTAKER Robt Cook

ADDRESS 1003 West Baltimore St.

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 56022

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 56022

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1134 W. Pratt ST. 18-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace Edna Caldwell

(a) RESIDENCE NO. 1134 W. Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Caldwell

6 DATE OF BIRTH (month, day, and year) May 24, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Minnesota

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. William J. Caldwell

(Address) 1134 W. Pratt St.

15 Filed APR 10 1930, 19 [illegible] Registrar

Important. See instructions on back of sheet.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 19 30 to April 10, 19 30, that I last saw her alive on April 9, 19 30 and that death occurred, on the date stated above, at 6.10 A. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Norwood, M. D.

APR 10 1930, 19 (Address) 939 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cemetery	Apr. 12 19 30
20 UNDERTAKER Ralph B. Cook	ADDRESS 1003 West Baltimore St

Spec.—8-16-29—L. F. S.—100 Bks.

R 56023

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56023

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME [illegible]

(a) RESIDENCE NO. [illegible] ST. [illegible] WARD [illegible]
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) [illegible] 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer [illegible]

9 BIRTHPLACE (city or town) [illegible]
(State or country) [illegible]

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country) [illegible]

14 Informant [illegible]
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 1 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-30

17 I HEREBY CERTIFY, That I attended deceased from 3-29-30, 19..., to 4-1-30, 19..., that I last saw h... alive on 4-1-30, 19..., and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy

Urinary retention (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of [illegible]

Was there an autopsy? To be performed.

What test confirmed diagnosis? [illegible]

(Signed) Edward Hinson Jr. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Albert cemetery	April 1 1930
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans st

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56024

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Ansquith St. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sr. M. Valentine Gladney

(a) RESIDENCE NO. Convent of Notre Dame ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Philip Gladney

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Regina Mueller

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sr. of Notre Dame
(Address)

15 Filed ..... 19 ..... Registrar

Important. See instructions on the back of this certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1931

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1931, to April 9, 1931, that I last saw h alive on April 9, 1931 and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Inoperable Cancer
r. Breast
Metastases in lungs

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual ms

(Signed) F. J. Kirby, M. D.

4/10, 1931 (Address) 1106 Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loch Cliff Md.	4/12/31
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay St.

Cor.—10-10-29—A Co.—100 Bks.

E 56025

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

182 E 56025

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Foot of Hull St. St. 22-30 Ward)

2-FULL NAME William Comer.(C)

(a) RESIDENCE NO. 722 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced.
HUSBAND of
(or WIFE of) Ida Comer.(C)

6 DATE OF BIRTH (month, day, and year) March 28,1892

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	0	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Ida Comer.(C) wife.
(Address) 722 Hanover St.

15 Filed ....., 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidentally dragged from a wharf during a storm.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

4/9, 1930 (Address) 1019 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	4/11, 1930
20 UNDERTAKER Arnold T. Steinsby	ADDRESS 78 Biddle

THE CAUSE OF DEATH must be entered properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HAMPSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

E 56026

HEALTH DEPARTMENT—CITY OF BALTIMORE

182 E 56026

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Foot of Hull St. St. 72-30 Ward)

2-FULL NAME William Johnson.(C)

(a) RESIDENCE NO. 722 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah Johnson.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	85	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Sarah Johnson.(C) wife.
(Address) 722 Hanover St.

15 Filed ... 19.. C. THAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APRIL 7, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidentally dragged from a wharf during a storm.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Inquiry.

(Signed) Otto M. Reinhardt M. D.

4/9, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. — DATE OF BURIAL 4/11/30

20 UNDERTAKER Samuel K. Hensley — ADDRESS 578 Eddie

Ref. _____

IMPORTANT—Answer each question in this certificate so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 56027 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56027

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. Md. Gen. Hosp. St. 15-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emma J. Drexel

(a) RESIDENCE NO. 2214 Poplar Grove St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Apr 21 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65 yrs.	9 mo.	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Werner Drexel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Brauns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Hosp. Records (Address)

15 Filed ... 19 ... Registrar C. HAMPSON JONES, M. D.

APR 11 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-9-30 19

17 I HEREBY CERTIFY, That I attended deceased from 4-7-30 . 19 . to 4-9-30 . 19 , that I last saw h[illegible] alive on 4-9-30 . 19 , and that death occurred, on the date stated above, at 10:25 P. m.

The CAUSE OF DEATH* was as follows:

C. V. D. Disease

(Cardio Vascular Renal Disease)

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. K. Vans M. D.

. 19 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount DATE OF BURIAL Apr 11 1930

20 UNDERTAKER John O. Mitchell ADDRESS Three 1900 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease TION is very important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56028

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56028

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 208 E. Lafayette av St. 4-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levin Claude Leatherbury

(a) RESIDENCE No. 208 E. Lafayette av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sadie Carruthers Leatherbury

6 DATE OF BIRTH (month, day, and year) June 4 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 06

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John E Leatherbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary L. Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Sadie C Leatherbury

(Address) 208 E Lafayette av

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1930, to April 9, 1930,

that I last saw him alive on April 9, 1930,

and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. M. Galant, M. D.

Apl 11 1930 (Address) 2413 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apl 12 1930
20 UNDERTAKER	ADDRESS
John C Mitchell & Son	1900 Eutaw Pl

TION is very important See instructions on back

C. HAMPSON JONES, M.D.

Spec.—1-30—M. & T.—250 Bks.

56029

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

√E 56029

46

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland ST. 16-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Sophie Kaplan

(a) RESIDENCE NO. 1612 - Arbutus ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
41				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Philip Kaplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca Nodel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Kaplan

(Address) 612 Arbutus St

APR 11 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/30

17 I HEREBY CERTIFY, That I attended deceased from 3/10, 1930, to 4/11, 1930, that I last saw her alive on 4/11, 1930, and that death occurred, on the date stated above, at 10:25 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma testis (Primary)

Ascites

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Cohen M. D.

4/11, 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom	4/11 1930

20 UNDERTAKER	ADDRESS
Jacob Lewis	1439 E Lombard St

Be sure to fill in all items. See instructions on back. It is very important.

Spec.—2-29-28—L. F. S.—500 Blks.

E 56030

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56030

101-001

CERTIFICATE OF DEATH

REGISTERED NO. 15-63

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3907 Dorchester Rd. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Milligan Gillespie Jr.

(a) RESIDENCE NO. 3907 Dorchester Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ? mos. ? da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Ellen Gillespie

6 DATE OF BIRTH (month, day, and year) May 25, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Fertilizer

(c) Name of employer: Baugh & Sons

9 BIRTHPLACE (city or town) (State or country): Rossville, Balto. Co., Md.

PARENTS

10 NAME OF FATHER: James M. Gillespie Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rising Sun Md.

12 MAIDEN NAME OF MOTHER: Emily Jane Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Timonium Md.

14 Informant: Miss Irene Gillespie

(Address): 3907 Dorchester Rd.

15 Filed APR 11 1930, C. HAMPSON JONES, [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-30

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 10, 1930, that I last saw h... alive on April 10, 1930 and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 2 wks

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence.

(Signed) Dr. B. Sybert, M. D.

, 19 (Address) 2802 Harford Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mr 12 1930
20 UNDERTAKER George Smith	ADDRESS 1532 Hollins

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

E 56031

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56031

101-001

CERTIFICATE OF DEATH

16-9

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St., 16-9 Ward)

2-FULL NAME Cecelia Leon

(a) RESIDENCE NO. 220 N Wolfe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? 1 yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	1	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Joe Peon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER 'Lena Fine

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Harry Leon
(Address) 220 N. Wolfe

15 Filed APR 11 1930 C. HAMPSON-JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10/30 '92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ... M. D.

4/11/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rt Carmel	4/11/30 19
UNDERTAKER	ADDRESS 1127
D. S. Levinson Bro	E. Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Marshall 1001

HEALTH DEPARTMENT—CITY OF BALTIMORE

56032

CERTIFICATE OF DEATH

E 56032

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St., W 20 Ward)

2-FULL NAME Timothy Marshall

(a) RESIDENCE No. 820 Bladen St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col'd	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Samuel Marshall

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Wynn

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Samuel Marshall
(Address) 820 Bladen St.

15 Filed Apr 10 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 2 yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Simple Meningitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? Regular
What test confirmed diagnosis? Regular

(Signed) H. Leland Smith M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 4/14/1930

20 UNDERTAKER Wm. Geo. A. Holland — ADDRESS 631 Druid Hill

C. HARRISON JONES, M. D.

APR 11 1930

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56033

CERTIFICATE OF DEATH.

E 56033

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 13-52 ST. WARD)

REGISTERED NO. 153

(If death occurred in a hospital or institution, give its NAME instead of street, and number.)

2-FULL NAME Mrs Lina (Caroline) Shelton

(a) RESIDENCE NO. 613 W. 40th St ST., WARD

(Usual place of abode)

(Length of residence in city or town where death occurred 61 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George W. Shelton

6 DATE OF BIRTH (month, day, and year) July 15, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: George E. Ruppel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth (unknown)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records

(Address)

15 Filed APR 11 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10 1930

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 10, 1930.

that I last saw her alive on April 10, 1930,

and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Cellulitis of right foot

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Septicemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 4/1/30 + 4/6/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory Findings

(Signed) [illegible] M.D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: Apr 14 1930.

UNDERTAKER: J. J. Tucker & Son

ADDRESS: [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Blks.

E 56034

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56034

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1722 Harford Ave ST. 9-18 WARD)

2-FULL NAME Sarah V. Vansant

(a) RESIDENCE NO. 1722 Harford Ave ST.; ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. (mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Henry Vansant

6 DATE OF BIRTH (month, day, and year) July 23 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md.

PARENTS

10 NAME OF FATHER Wm Harvey Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md.

12 MAIDEN NAME OF MOTHER Rachael Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co. Md.

14 Informant Mrs. Irene Dixon

(Address) 1722 Harford Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1930

17 I HEREBY CERTIFY, That I attended deceased from the year 1924 to April 8 1930,

that I last saw her alive on " 7 1930,

and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(duration) 6 yrs. ... mos ... da.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby M. D.

4/8/1930 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Carrs Cem. Balto Co. Md	Apl 11 1930
20 UNDERTAKER	ADDRESS
Wm Fluckner Sons	North Ave

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 56035

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 ✓ E 56035

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 E Monument St. 5-8 WARD)

2-FULL NAME Eugene Johnson.

(a) RESIDENCE NO. 1315 E. Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernice Johnson.

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. C.D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Burk Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Nellie Johnson. (Address) 1315 E. Monument.

Filed , 19 Registrar

CAUSE OF DEATH in plain English and as fully as possible. See instructions on back of certificates. IMPORTANT.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8- 1930

17 I HEREBY CERTIFY, That I attended deceased from 2-20-, 1930, to 4-8-, 1930, that I last saw h— alive on 4-7-, 1930 and that death occurred, on the date stated above, at 11,15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvulets.

(duration) entire yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) B. H Bagwill, M. D.

4-9-, 1931 (Address) 611 N. Carol

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem — DATE OF BURIAL: 4-11 1930

20 UNDERTAKER: Byron Wright — ADDRESS: 1218 McElderry St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 ✓

E 56036

REGISTERED NO. E 56036

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

City of Baltimore: (No. 904 Boyd St., 18-29 Ward)

2-FULL NAME Sarah M. Jones

(a) RESIDENCE NO. 904 Boyd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Elmer Tingley
(Address) 845 Boyd St

15 Filed ..... 19.. ..... Registrar

APR 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Gellard, M. D.

4/10. 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MT Auburn Cem	4-11 1930
20 UNDERTAKER Daniel Carlon	ADDRESS 916 Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

56037

1-PLACE OF DEATH

City of Baltimore: (No. 221 E. Biddle St., 4-25 Ward)

2-FULL NAME Israel Gilbert

(a) RESIDENCE NO. 1614 Monument St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

90 ✓ E 56037

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	Mar

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Servant 610
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Police Department
(Address)

15 Filed APR 1 1930 19 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8. 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation
Probable Cardiac Thrombosis
Senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. T. Ruby, M. D.

4-10, 1930 (Address) 1639 Bonaparte

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 4-11 1930

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

56038

REGISTERED NO. 181 E 56038

1-PLACE OF DEATH

City of Baltimore: (No. 5926 Kavon Ave (Raspberry) Ward) 26-42

2-FULL NAME Charles C. Debes

(a) RESIDENCE NO. 5926 Kavon Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora Debes

6 DATE OF BIRTH (month, day, and year): Oct 26/1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Salesman (self)
(b) General nature of industry, business, or establishment in which employed (or employer): Auto Tires
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: John A. Debes

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Clara Wagner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Germany

14 Informant: Mrs. Cora Debes (wife)
(Address): 5926 Kavon Ave

15 Filed APR 11 1930 19 C. HAMPSON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

Probably Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Bacon, M. D.

4/10/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Apr. 12 1930
20 UNDERTAKER	**ADDRESS**
Henry Hoeck Sons, Inc.	1301 E Eager St

Spec.-7-17-26—A Co.—200 Blks.

E 56039

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56039

179

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 903 McHenry St. 21-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie A Fitzsimons

(a) RESIDENCE NO. 903 McHenry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Fitzsimons

6 DATE OF BIRTH (month, day, and year): 4/4/1875

7 AGE: Years 65 Months Days 5 IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto Md

(State or country):

PARENTS

10 NAME OF FATHER: John O Rourke

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country):

12 MAIDEN NAME OF MOTHER: Mary Roche

13 BIRTHPLACE OF MOTHER (city or town): Ireland

(State or country):

14 Informant: James Fitzsimons

(Address) 2411 Westfield ave

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April. 9. 1930.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 7. 1930, to Apr. 9. 1930,

that I last saw her alive on Apr. 9. 1930;

and that death occurred, on the date stated above, at 4-45 P M

The CAUSE OF DEATH* was as follows:

Uter. Endocarditis.

(duration) yrs. mos 3 da.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis.

(duration) yrs. 6 mos da.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam Etc.

(Signed) Thos Fenton, M. D.

4/9/30 19 (Address) 886 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial 4/12/30

20 UNDERTAKER: H C Bramings Son — ADDRESS 1136 Poplar Grove st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56040

CERTIFICATE OF DEATH.

90

E 56040

1-PLACE OF DEATH

28-63

REGISTERED NO._____

City of BALTIMORE: (No. 3904 Gwyn Oak Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph C. Forman

(a) RESIDENCE NO. 3904 Gwyn Oak Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta F. Forman

6 DATE OF BIRTH (month, day, and year) Dec. 23rd. 1870.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	59	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Father

9 BIRTHPLACE (city or town)

(State or country) Russia.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs. Henrietta Forman

(Address) Park Circle Apts.

very important. See instructions on back of ...

Filed ..... 19 ..... Registrar

R 1 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 6th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Mitral Stenosis

2 .....

3 .....

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ..... M. D.

18 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Baltimore Hebrew Cemetery	4/ 11/ 1930

20 UNDERTAKER Baird Sonnheim

ADDRESS 118-20 W. Mt. Royal Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56041 — 161-001 — E 56041

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2501 W. Lafayette ave. 4-6-68 WARD)

2—FULL NAME Ruby Schwarze.

(a) RESIDENCE NO. 2501 W Lafayette ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-11-30

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 7 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Conrad B. Schwarze.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Night Fraher

13 BIRTHPLACE OF MOTHER (city or town) Catonsville
(State or country) Md.

14 Informant Conrad B. Schwarze.
(Address) 2501 W. Lafayette ave.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11-1930

17 I HEREBY CERTIFY, That I attended deceased from April 11- 1930, to April 11- 1930, that I last saw her alive on April 11- 1930 and that death occurred, on the date stated above, at 3:07 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Size & child.

(Signed) Clayton Piland. M. D.

4-11-1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cem. DATE OF BURIAL Apr. 12 1930

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

Spec.—8-16-29—L. F. S.—100 Bks.

E 56042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 ✓

E 56042

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2501 W. Lafayette Ave ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby, Schwarze

(a) RESIDENCE NO. 2501 W. Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-11-30

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
	—	—	—	4 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Conrad D. Schwarze.

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Nagel Fisher

13 BIRTHPLACE OF MOTHER (city or town) Catonsville
(State or country) Md

14 Informant Conrad D. Schwarze
(Address) 2501 W. Lafayette ave

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

4 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11-1930

17 I HEREBY CERTIFY, That I attended deceased from April 11-, 1930, to April 11-, 1930, that I last saw her alive on April 11-, 1930, and that death occurred, on the date stated above, at 3:09 a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Size of child.

(Signed) Chester Riland, M. D.

4-11-1930 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Johns Cem, Edgr.	Apr. 11 1930

20 UNDERTAKER Easton Sons, ADDRESS Ellicott City

Cor.—10-10-29—A C.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56043 — 74-001 — E 56043

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1207 Mosher St.) 16-23 (Ward)

2-FULL NAME John Brown

(a) RESIDENCE NO. 1207 Mosher St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Alice Brown

6 DATE OF BIRTH (month, day, and year) Dec 25th 1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	67	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer): Private
(c) Name of employer: Charles Co Md

9 BIRTHPLACE (city or town) (State or country): Charles Co Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Florence Williams
(Address) 1209 Mosher

15 Filed ..... 19.. HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 29 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Influenza (duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. Griffith M. D.

(Address) Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elkridge Md	4-12 1930

20 UNDERTAKER Joseph A Lively ADDRESS 409 N Mount

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56044 — 154-002 — E 56044

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1814 Monrell Park Ave ST., 25-72 WARD

2-FULL NAME Gloria Gibson

(a) RESIDENCE NO. 1814 Monrell Park Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none yrs

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Oscar R Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Blanche H Hoenig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Oscar Gibson

(Address) 1814 Monrell Park Ave

15 Filed April 11, 1930 Registrar

APR 11 1930 C. H. Dept.

Pd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1930

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to April 11, 1930

that I last saw her alive on April 8, 1930

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of the Heart

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Gertrude Kieffer, M. D.

19 (Address) 2537 Bank Blvd April 11 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 4/11 1930

20 UNDERTAKER Edward Toulson

ADDRESS 2357 Wash Blvd

CAUSE OF DEATH—In violent deaths state whether accident, suicide or homicide. Fill in all blanks with definite statements, if unknown state so. Indefinite and unsatisfactory answers will be returned for correction. Physicians are required to report cases of death without medical attendance. See instructions on back of certificates. TION is very important.

Spec. 8-16-29 L. F. S. 100 Blks.

E 56045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 100

1—PLACE OF DEATH Janina MASZEZYNSKI

CITY OF BALTIMORE: (No. 215 S Collington ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Janina Maszczynski

(a) RESIDENCE NO. 215 S Collington ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): December 25-1928

7 AGE: Years 1 | Months 3 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Antoni Maszczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Waszeki

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Mrs Mary Maszczynski

(Address) 215 S Collington ave

15 Filed APR 11 1930 C. HAMPSON JONES, M. D. Registrar

By R Clk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/10/30

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to April 10, 1930, that I last saw her alive on April 10, 1930, and that death occurred, on the date stated above, at 5:35 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Alex Szczukiewski, M. D.

4/11, 1930 (Address) 3579 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cemetery — DATE OF BURIAL: April 12 1930

20 UNDERTAKER: George A Weber — ADDRESS: Lamont

Spec.—8-16-29—L. F. S.—100 Bks.

E 56046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 14-00 E 56046

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 Edgewood ST. 8-7-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa B. Laffey.

(a) RESIDENCE NO. Hanover Maryland ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 7 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female.	white	Single.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 4th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53.	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Michael Laffy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine Hanlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Mary Laffey.

(Address) Hanover, Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9th 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 9 1930, to April 9 1930, that I last saw her alive on April 9 1930 and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage - Right Hemiplegia 9 hours 30 min.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) (duration) yrs mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis & Coma

(Signed) M. Gibson Forlin, M. D.

4/10, 1930 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Augustine's Cem Elkridge	Apr 12 1930
20 UNDERTAKER John G. Cowan & Son.	ADDRESS Govanstown

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56047

90 E 56047

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3231 E. Baltimore ST., 10-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth. Simms

(a) RESIDENCE NO. 3231 E Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 6 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 27th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58.	6	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles W. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Hetherington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mary Land.

14 Informant Mrs Mary E. Schoch.

(Address) 3231 E Balto St.

15 Filed APR 11 1930 CLAYTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 31 1929 to April 10th 1930,

that I last saw her alive on April 10th 1930,

and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel B Wolfe, M. D.

4/12 1930 (Address) 1331 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn, Balto.

DATE OF BURIAL 4-13 1930.

20 UNDERTAKER Bolton Lowe & Son

ADDRESS Woodlawn

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56048 E 56048

CERTIFICATE OF DEATH. 31

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST. 8-16 WARD)

CITY OF BALTIMORE: (No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Trojansky

(a) RESIDENCE NO. 1850 N. Collington ave ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
58	57 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Casameria Trojansky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Agnes ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records (Address)

15 Filed APR 1 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1929, to April 9, 1930, that I last saw him alive on April 9, 1930, and that death occurred, on the date stated above, at 8.48 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [signature] M. D.

4-10 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL April 12 1930

20 UNDERTAKER A. W. Ozazewski 19 S. Eastern ADDRESS

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56049

CERTIFICATE OF DEATH.

38

E 56049

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Bleecker ST., 5-9 WARD)

2-FULL NAME Zenobia Collins

(a) RESIDENCE NO. 1423 Bleecker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced (or) WIFE of Thomas Collins

6 DATE OF BIRTH (month, day, and year) Feb 2, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0'0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Falls. Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Mary Dixon

(Address) 1610 Pa. Ave

15 Filed APR 11 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to April 9, 1930, that I last saw him alive on April 9, 1930, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis + Hypostatic

over

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Inflation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. L. J. Perry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	Apr. 12 1930

20 UNDERTAKER Thos J. Ls Sons ADDRESS 1302 Pitts

CAUSE OF DEATH must be filled in by physician. See instructions on back of certificates. TION is very important.

Spec.—1-30—M. & T.—250 Bks.

E 56050

HEALTH DEPARTMENT—CITY OF BALTIMORE

100 1901 E 56050

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto City Hosp. 26-36 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl ~~Emma~~ Curcio

(a) RESIDENCE NO. 6743 Holabird Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-6-00

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Carmine Curcio.

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Greco

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country) Italy

14 Informant Hospital Records.
(Address) Balto City Hosp.

15 Filed APR 7 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-30

17 I HEREBY CERTIFY, That I attended deceased from 4-6, 1930, to 4-10, 1930, that I last saw h[illegible] alive on 4-10, 1930, and that death occurred, on the date stated above, at 7:20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam.

(Signed) Fred M. Buckwalter, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus

DATE OF BURIAL Apr 2 1930

20 UNDERTAKER Joseph Ulrich

ADDRESS 2205 Eden

Spec.—1-30—M. & T.—250 Bks

Dr. Benson Overlea Ave - Overlea ✓ 0° V

E 56051

HEALTH DEPARTMENT—CITY OF BALTIMORE

91 0° E. 56051

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5904 Kavon Ave St. 26-42 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Salisbury

(a) RESIDENCE NO. 5904 Kavon Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of William E. Salisbury

6 DATE OF BIRTH (month, day, and year) Aug 7th 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Margaret Markin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Wm E. Salisbury

(Address) 5904 Kavon Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1927, to April 9th, 1930,

that I last saw h— alive on April 9th, 1930,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Uterine Sclerosis

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward Krause, M. D.

4/10, 1930 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 4/12/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

FOR A VERY important

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56052

CERTIFICATE OF DEATH

90 E 56052

1-PLACE OF DEATH

City of Baltimore: (No. 1851 Lorman St., 15-22 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Swoboda Kemple

(a) RESIDENCE NO. 1851 Lorman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Paul J. Kemple
(Address) 1851 Lorman

15 Filed ....., 19.... Registrar

1884

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry)... thereon and from the evidence obtained by said Inquest find that said deceased came to ....(Inquest, autopsy or inquiry)... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Ruth A Brush M. D.

19 (Address) Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	6/11/30
20 UNDERTAKER	**ADDRESS**
Wm Cook & Co	17 N Paul

OF DEATH in plain terms, so that it may be properly classified. Each statement of cause of death important. See instructions on back of certificate.

Spec.—1 30—M. & T.—250 Bks.

E 56053

E 56053

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56053

37

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (No. ..... ST., 5-8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Cinquegrani

(a) RESIDENCE NO. 426 N. Exeter st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Cinquegrani

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Italy

12 MAIDEN NAME OF MOTHER Augustina La Scola

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Italy

14 Informant Hospital Records
(Address) .....

15 Filed APR 1 1930 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to April 10, 1930,

that I last saw him alive on April 10, 1930,

and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ..... mos ..... da.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What tests confirmed diagnosis? Clinical

(Signed) Jos Cinquegrani Jr. M.D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster, Govans

DATE OF BURIAL 4/12 1930

20 UNDERTAKER W. H. Cook

ADDRESS 1217 E. Pratt St

Spec.—1-12-23—M&T—500 Blks.

E 56054

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56054

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jenkins Memorial Hospital

CITY OF BALTIMORE: (No. 1600 Caton Avenue ST. 8-12 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Gittings

(a) RESIDENCE NO. 2425 E. Preston ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J. Gittings

6 DATE OF BIRTH (month, day, and year) About 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Scherer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Jenkins Memorial Hosp.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

THIS is very important—See instructions on back

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1930

17

I HEREBY CERTIFY, That I attended deceased from February 13, 1930, to April 9, 1930,

that I last saw her alive on 4-9, 1930,

and that death occurred, on the date stated above, at 8:25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast (left)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 4/12/1930

20 UNDERTAKER Wm Cook

ADDRESS 1207 St Paul St

Spec.—1-30—M. & T.—250 Blks

Dr Monnus Kin 800 E. North Ave

E 56055

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56055

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2801 Matthews ST. 9-th WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret T. Stinefelt

(a) RESIDENCE NO. 2801 Matthews ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Chas H. Stinefelt

6 DATE OF BIRTH (month, day, and year) 5/4/1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas M Stinefelt
(Address) 2801 Matthews St

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10th 1930

17

I HEREBY CERTIFY, That I attended deceased from Mar 28, 1930, to Apr 10, 1930, that I last saw her alive on Apr 10th, 1930, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur C Monnuger, M. D.

4/10, 1930 (Address) 800 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL 4/14/30

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—1-10-21—MAT—1500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56056

CERTIFICATE OF DEATH.

E 56056

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No.) Caudenor Ave St. (Ward) 11

2-FULL NAME Mrs Elizabeth Adams

(a) RESIDENCE NO. Upper Pres Rd Harford Co. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J. Adams

6 DATE OF BIRTH (month, day, and year) march 24 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Harford co md

PARENTS

10 NAME OF FATHER Hanson Ayers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford co md

12 MAIDEN NAME OF MOTHER [redacted]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Wm J Adams (Address) Fallston md

15 [illegible] 1930 Registrar R R M

R 11 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1930

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to April 11, 1930, that I last saw h[illegible] alive on April 11, 1930, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Umbelical Hernia (Incarcerated)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of April 9 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Thomas, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. †See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Highland cem	Apr 14 1930

20 UNDERTAKER C E Gruntzdorf

ADDRESS Jarrettsville Md

CAUSE OF DEATH to be plainly written, so that it may be properly coded. See instructions on back of certificate. TION is very important.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56057 X 762 E 56057

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Hauck

(a) RESIDENCE NO. Westport, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth R. Hauck

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1888

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	41	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler-Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer McNamara Bros. Co.

9 BIRTHPLACE (city or town) Baltimore Co.,

(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph T. Hauck

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Louisa Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Mrs. Elizabeth R. Hauck

(Address) Westport, Md.

15 Filed ..... 19 .....

1930 RRH. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR. 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture - Right Femur.
Accidental Death. Boiler fell on him at work.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. ds.

(Signed) Eugene Zeller, M. D. (Coroner)

4/11 19 30. (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

2826 Kloman St.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial April 14 1930

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

very important. See instructions on back

Spec.—1-10-21—M&T—1500 Blks.

E 56058

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56058

CERTIFICATE OF DEATH.

117

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 27-54 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elizabeth O'Connell

(a) RESIDENCE NO. 5926 Falls Rd Mt. Wash. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mt Washington

PARENTS

10 NAME OF FATHER Patrick O'Connell

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs. Mary O'Connell 5926 Falls Rd Mt Wash

15 Filed . 19 1930 Registrar ARH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-6 . 1930, to 4-11 . 1930.

that I last saw h[illegible] alive on 4-11 . 1930,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Embolism

(Pelvic adhesions - Chronic appendicitis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abdominal pain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 21-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Ferdinand P. Mueller, M. D.

. 19 (Address) 1 East Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Jerusalem Cemetery DATE OF BURIAL Apr-14-30

20 UNDERTAKER A S Marshall ADDRESS 3539 Fulton Ave

TION is very important See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56059

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Joseph Hospital — REGISTERED NO. 24-35

CITY OF BALTIMORE: (No. Charlotte & ours ST., 7 WARD)

2-FULL NAME Anna Flynn

(a) RESIDENCE NO. 1307 Hanover ST WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin M. Flynn

6 DATE OF BIRTH (month, day, and year): Jan 12. 1891

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cecelia Flynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Martin M. Flynn 1307 Hanover St

15 Filed APR 1 1930 — G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-8-30, 19 , to 4-9-30, 1930, that I last saw h alive on 4-9-30, 1930, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

E Hemiplegia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Cardiac Decadence

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) N. M. Flynn M. D.

4/9, 1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. — DATE OF BURIAL: April 12 30

20 UNDERTAKER: Margaret A. Flynn — ADDRESS: 1422 Light

CAUSE OF DEATH. See instructions on back of certificates. ATTENTION is very important

Spec. 1-30—M. & T.—250 Bks.

E 56060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 E 56060

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Castle ST., 2-4 WARD)

2-FULL NAME John Duschl

(a) RESIDENCE NO. 107 S. Castle ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1st 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher at 13

(b) General nature of industry, business, or establishment in which employed (or employer) S. K. Plant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Matthias Duschl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Cummings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Matthias Duschl (Father) (Address) 107 S. Castle St.

15 Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 6 , 1930, to Apr 9 , 1930, that I last saw h alive on Apr 8 , 19 30 and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 da.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

19 (Address) 430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	April 12 1930
20 UNDERTAKER Lilly & Sons Inc.	*ADDRESS 733 S. Hope

Spec.—1-30—M. & T.—250 Bks.

D56061

E 56061 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56061

CERTIFICATE OF DEATH. 74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2502 Gibbons Ave (ST.) 27 (WARD)

2-FULL NAME Euphemia Denny.

(a) RESIDENCE NO. 2502 Gibbons Ave ST. Hamilton (Ave) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3-0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Denny

6 DATE OF BIRTH (month, day, and year) Aug 10, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Ellen Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va.

12 MAIDEN NAME OF MOTHER — Blanchelift

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va.

14 Informant Mrs Harry Bush (Daughter) (Address) 2502 Gibbons Ave

15 Filed APR 2 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11-30

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to April 10, 1930, that I last saw h[illegible] alive on April 10, 1930, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Dr

Did an operation precede death? Dr Date of

Was there an autopsy? Dr

What test confirmed diagnosis? Clinical

(Signed) D. A. Thompson Jones M. D.

4-11-1930 (Address) 2711 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	April 14 '30

20 UNDERTAKER Edmund W. Bonsal ADDRESS 924 E. Eager St.

Spec.—1-10-21—M&T—1500 Blks.

E 56062

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56062

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 333 Dolphin St. St. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Adolph Arnold

(a) RESIDENCE NO. 333 Dolphin St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 22 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Business (Salesman).

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md —

PARENTS

10 NAME OF FATHER Richard H. Arnold —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Saxony Germany.

12 MAIDEN NAME OF MOTHER Amelia Maria Borchert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Germany.

14 Informant (Address) Miss Emma Arnold 333 Dolphin St.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to April 10, 1930,

that I last saw him alive on April 10, 1930,

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 15 yrs 2 mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Laboratory

(Signed) Chas. Carlton Stewart, M. D.

3/10, 1930 (Address) 738 E. 20th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: April 12 1930

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North ave

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56063

E 56063

CERTIFICATE OF DEATH

1-PLACE OF DEATH West Baltimore General Hospital

CITY OF BALTIMORE: (No. Baltimore, ST., 1426 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Brown

(a) RESIDENCE NO. 1307 W. Mulberry ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Brown (Goldsborough)

6 DATE OF BIRTH (month, day, and year) Oct 6, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steveder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Olon Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) S C

12 MAIDEN NAME OF MOTHER Fora Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S C.

14 Informant Mary Goldsborough

(Address) 1307 W Mulberry

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-3-, 1930, to 4-11, 1930, that I last saw h[illegible] alive on 4-11-30, 19 and that death occurred, on the date stated above, at 8 30 a m

The CAUSE OF DEATH* was as follows:

~~Carcinoma~~ Abscess of liver

(duration) yrs. ? mos. 8 ds.

CONTRIBUTORY (Secondary) ~~Abscess of liver~~ peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 4-3-30

Was there an autopsy? Yes autopsy findings

What test confirmed diagnosis?

(Signed) S A Alessi M. D.

, 19 (Address) West Bal'd Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rowesville, S.C.

DATE OF BURIAL April 3, 1930

20 UNDERTAKER Mrs. Katie R Williams

ADDRESS Schroeder St

TION is very important. See instructions on back of Certificate.

E. C. HAMPSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56064

101-001 E 56064

CERTIFICATE OF DEATH

23-31

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1013 Plum Alley. St. (Ward)

2-FULL NAME Natalie Winston.(C)

(a) RESIDENCE NO. 1013 Plum Alley- St.____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) June 22, 1913

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	16	9	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John Winston.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 ~~MAIDEN~~ NAME OF MOTHER Mary Byus.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant John Winston.(C) father.
(Address) 1013 Plum Alley.

15 Filed _____, 19____ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

_____ (duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

_____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) H. Moll Eberhardt M. D.

4/11, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	5 12 1930
20 UNDERTAKER	ADDRESS
R L Parham	1007 N. Monroe

OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 56065

234519

HEALTH DEPARTMENT—CITY OF BALTIMORE

146

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 10-14 WARD)

2—FULL NAME Audrey Carroll

(a) RESIDENCE NO. 1811 Ensor ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard Carroll

6 DATE OF BIRTH (month, day, and year) Oct. 11 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER William Tabron

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Lula Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 7 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1930, to April 9, 1930, that I last saw h.. alive on April 9, 1930 and that death occurred, on the date stated above, at 5 45 A. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of about Mar. 10

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture

(Signed) J. F. Snyder, M. D.

4-9, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Ct	April 12 1930
20 UNDERTAKER	ADDRESS
O. R. Brown & Son	108 W. Monument St

Spec.—1-30—M. & T.—250 Bks

E 56066

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56066

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Mount ST. 15-21 WARD)

2-FULL NAME Mary Sydnor Weston

(a) RESIDENCE NO. 1423 Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Philip Weston

6 DATE OF BIRTH (month, day, and year) 4-13-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex Co. Va

PARENTS

10 NAME OF FATHER John Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co. Va

12 MAIDEN NAME OF MOTHER Sarah Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co. Va

14 Informant James Sydnor (Address) 1423 Mount St. D

15 Filed ....., 1930 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11-30

17 I HEREBY CERTIFY, That I attended deceased from 4-3-, 1930, to 4-11-, 1930, that I last saw her alive on 4-11-, 1930, and that death occurred, on the date stated above, at 2: P m.

The CAUSE OF DEATH* was as follows:

Bilateral lobar pneumonitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Franz Saunders, M. D.

4-12-1930 (Address) 1029 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn Cemetery

DATE OF BURIAL April 14, 1930

20 UNDERTAKER

Wm. Nate R. Williams

ADDRESS 3221 Schroeder St

Spec.—2-29-28—L. F. S.—500 Blks.

E 56067

HEALTH DEPARTMENT—CITY OF BALTIMORE

57 E 56067

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N. Washington ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Kerner

(a) RESIDENCE NO. 525 N Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced (or) WIFE of: George Kerner

6 DATE OF BIRTH (month, day, and year): Aug 19-1858

7 AGE: Years 71 | Months 7 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Delta Ind

PARENTS

10 NAME OF FATHER: Geo. Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Feintuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Carrie Feininger

(Address) 525 N Washington

15 Filed , 19 Registrar

R 12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9-1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1927 to April 9, 1930, that I last saw her alive on April 8, 1930 and that death occurred, on the date stated above, at 10:25 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What (eat confirmed diagnosis?

(Signed) Edward J Level, M. D.

4/9, 1930 (Address) 416 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: April 12 1930

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans St.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56068

E 56068

CERTIFICATE OF DEATH

24-001

24-35

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1807 Haubert St. St., (Ward)

2-FULL NAME Bridget Hart.

(a) RESIDENCE NO. 1447 Andre St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. 11 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Michael Hart.

6 DATE OF BIRTH (month, day, and year) April 30, 1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs or min.
	86	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael McHale.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ellen Clark.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Michael Hart. (husband)
(Address) 1447 Carlington Road, Govans, Md.

15 Filed APR 12 1930 19 By Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto E. Reinhardt, M. D.

4/11, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 14 1930
20 UNDERTAKER Chas. P. Stevens	ADDRESS 1500 E Fort Ave

OF DEATH in plain terms, so that it may be properly classified. All questions must be answered if possible, as every item is important. See instructions on back of certificate.

E 56069

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56069

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1534 McCulloh St. (WARD) 14-20

2-FULL NAME Charles Franklin Thomas.

(a) RESIDENCE NO. 1534 McCulloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Katie Thomas

6 DATE OF BIRTH (month, day, and year): Feb 22 1870

7 AGE: Years 60 | Months 1 | Days 18 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: Isaac Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Rosa ann Boat.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Katie Thomas 1534 McCulloh st

15 Filed 1-2 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 8th, 1930, to April 9th, 1930, that I last saw him alive on April 9th, 1930, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cerebral Hypertension (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Harry L. Brown, M. D.

4/10/1930 (Address) 1916 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: 4/12 1930

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Pennsylvania Ave

THIS IS VERY IMPORTANT — BE HAMPSON LANES, M

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56070

E 56070

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1323 Woodyear ST. 15-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Forbes

(a) RESIDENCE NO. 1323 Woodyear ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Forbes

6 DATE OF BIRTH (month, day, and year) July 24 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laplata Md

PARENTS

10 NAME OF FATHER Charles Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Laplata Md

12 MAIDEN NAME OF MOTHER Mary Hurd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Laplata Md

14 Informant Maud Watts

(Address) 1323 Woodyear St

15 Filed 2-1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-30

17 I HEREBY CERTIFY, That I attended deceased from 2-26- 1929 to 4-10- 1930.

that I last saw her alive on 4-9- 1930.

and that death occurred, on the date stated above, at 3:40 P m.

The CAUSE OF DEATH* was as follows:

Nephritis (interstitial chronic)

(duration) 1 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Mic. Examination

(Signed) Frank A Saunders M. D.

4-10-1930 (Address) 1024 N Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters cemetary

DATE OF BURIAL 4/14 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pleasant St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56071 90 ✓ E 56071

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. _____

CITY OF BALTIMORE: (No. 1306 Madison Ave. St. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adelea Ringgold

(a) RESIDENCE NO. 1306 Madison Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Caleb Ringgold

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) unk

12 MAIDEN NAME OF MOTHER Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles Ringgold

(Address) 1306 Madison Ave

15 Filed _____ . 19 _____ HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10-30

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to April 10, 1930, that I last saw h[illegible] alive on April 10, 1930 and that death occurred, on the date stated above, at 10:00 P.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Cardio Renal disease

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo Adler, M. D.

4-10-1930 (Address) 508 Lenox St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 4/14 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Preston St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 504 W. Barre St. WARD) 7-30

2-FULL NAME Infant daughter of Mr + Mrs. Geo. H. Zoby Jr.

(a) RESIDENCE NO. 504 W. Barre ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 161 E 56072

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 11, 1930

7 AGE: Years | Months | Days | If LESS than 1 day, 6 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo. H. Zoby Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary E. Krowsman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Geo. H. Zoby Jr 504 W. Barre St

15 Filed 4 12 1930 . 19 Registrar: HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 11, 1930, to Apr. 11, 1930 that I last saw h[illegible]alive on Apr. 11, 1930 and that death occurred, on the date stated above, at 7:45 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion (duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) J. L. Campbell M. D.

4/11, 19 30 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem DATE OF BURIAL 4/12/30

20 UNDERTAKER: Engelke & Turley ADDRESS Fulton & Fayette

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56073

CERTIFICATE OF DEATH

185 E 56073

1—PLACE OF DEATH

REGISTERED NO. 13-57

CITY OF BALTIMORE: (No. Union Mem. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Hetrick

(a) RESIDENCE NO. 3105 Kenwick Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Mr. ? Hetrick

6 DATE OF BIRTH (month, day, and year) July 3, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Adelsperger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Mary Hetrick

(Address) 3105 Kenwick Rd.

15 Filed APR 9 1930, 19 HAMPSON JONES, M. D. Registrar

1 21930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1930, to April 9, 1930, that I last saw h.er alive on April 9, 1930 and that death occurred, on the date stated above, at 11:45 P.m.

The CAUSE OF DEATH* was as follows:

Fracture Zygoma R.

Fracture L. Ext. Malleolus

Contusion & Ecchymosis Face

Coroner Inquest (duration) Hours mos. 16 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Dying at home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clin. findings

(Signed) A. R. Wilkinson, M. D.

4/9/1930 (Address) Union Mem. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Mary Hayden	April 12, 1930
20 UNDERTAKER	ADDRESS
Ehrenfeld Son	2405 Eastern

Spec.—1-30—M. & T.—250 Bks

E 56074 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 308. Bethel. ST. B-4 WARD) 100-01

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. E. Markowski

(a) RESIDENCE NO. 308. S. Bethel. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 14-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md,

PARENTS

10 NAME OF FATHER Alexander Markowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary. Wojtkiewicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Felix Markowski

(Address) 308 S Bethel St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 - 30

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to April 11, 1930, that I last saw him alive on April 11, 1930, and that death occurred, on the date stated above, at 10 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchio Pneumonia

(Primary) (duration) yrs. mos 22 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X

4/1, 1930 (Signed) Karl Steingler, M. D.

(Address) 1002 E Baltr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL 4/12 1930

UNDERTAKER Wm Piatkowski 1618 — ADDRESS Eastern Ave

Spec.—1-30—M. & T.—250 Bks

E 56075 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56075

CERTIFICATE OF DEATH. REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1608 Holbrook ST., 9-18 WARD)

2-FULL NAME Alice T. Furlong

(a) RESIDENCE NO. 1608 Holbrook ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of John Furlong

6 DATE OF BIRTH (month, day, and year) 12/20/1857

7 AGE: Years 72 Months 3 Days 22 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md.

PARENTS

10 NAME OF FATHER David Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rose Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Thomas Furlong 1608 Holbrook St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929 to April 11, 1930

that I last saw h[illegible]ive on April 11, 1930 at 4 a.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wilson Thomas, M. D.

(Address) 1228 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's - Govanstown DATE OF BURIAL 4/14/30

UNDERTAKER Mary T. Ruth ADDRESS 1235 Harford

C. HAMPSON JONES, M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56076

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 56076

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital 8-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George J. Hildebrand.

(a) RESIDENCE NO. 1627 N. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., If foreign birth? —yrs. —mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/2/1888

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	42	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Brokerage

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph F. Hildebrand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Madden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs. Wm Henry

(Address) 1627 N. Bond St

15 Filed 1 2 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/30

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1930, to 4/11, 1930,

that I last saw him alive on 4/11, 1930

and that death occurred, on the date stated above, at 11 15 a m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis
Hypertension - uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 0

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & exam.

(Signed) Thos. E. Stacy Jr., M. D.

, 19 (Address) Bon Secours Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 4/14/30 19

20 UNDERTAKER Mary T. Ruth Sons

ADDRESS 1335 Hanford

Spec.—8-1929—L. F. S.—100 Bks.

E 56077

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56077

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Charles Harridy

(a) RESIDENCE NO. 708 South Sharp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-27-1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
38 yrs		0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 04

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER James Harridy

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Christina Sauer.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Hospital Records
(Address)

15 Mar ... 2 1930 ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8th 1930

17

I HEREBY CERTIFY, That I attended deceased from March 13th, 1930, to April 8th, 1930, that I last saw him alive on April 8th, 1930 and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Heart Disease Hypertensive with Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) William H. Varney M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Natemah Cemtery DATE OF BURIAL 4/12

20 UNDERTAKER Walter S. Spriggs ADDRESS 109 N Fremley

Cor.—10-10-29—A Co.—100 Bks.

E 56078 ✓ E 56078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 101-001

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 9-9 Ward)

2-FULL NAME Alice Braxton

(a) RESIDENCE NO. 411 Railroad Ave., Towson, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	black	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thomas Braxton

6 DATE OF BIRTH (month, day, and year) Aug 16/1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
36	37	7	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Towson, Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Williams

11 BIRTHPLACE OF FATHER (city or town) Towson, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Meyers

13 BIRTHPLACE OF MOTHER (city or town) Towson, Md.
(State or country)

14 Informant Thomas Beaxton
(Address) 411 Railroad Ave., Towson

15 Filed APR 12 1930 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10-30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Cardiac Failure (Died during entrance examination)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) _____, M. D.

4/11/30 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md. Pleasant Rest Towson	4-13 1930
20 UNDERTAKER	ADDRESS
Byron Wright	1218 N. Calvert St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56072

CERTIFICATE OF DEATH

179 E 56079

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2125 Madison Ave. (WARD) 59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ophelia Hicks

(a) RESIDENCE NO. 2125 Madison Ave. STR. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	S.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 2 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Albert Hicks

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Daisy Burton

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Albert Hicks. (Address) 2125 Madison Ave.

15 Filed ... 19 ... Registrar

C. HAMPSON JONES M.D.

APR 21 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 10, 1930, that I last saw her alive on April 10, 1930, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Acute Hydrocephalus following a severe accidental Burn of leg & face

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Severe Burn (duration) 1 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) G. J. Hall, M. D.

. 19 (Address) 426 E. 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary cem. DATE OF BURIAL Apr 12 1930

20 UNDERTAKER Mrs B. A. Elliott ADDRESS 1725 Eutaw

Spec.—8-16-29—L. F. S.—100 Bks.

Mary Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

2314 550
E 56080
Fred

129 VE 56080

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Smith

(a) RESIDENCE NO. 701 N. Carlton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Smith

6 DATE OF BIRTH (month, day, and year) 11-22-91

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38		16	
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer — 031

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Emerson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lydia Masten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-30

17 I HEREBY CERTIFY, That I attended deceased from 3-12, 1930, to 4-, 1930,

that I last saw h alive on 4-5, 1930

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) a/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) anemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What lest confirmed diagnosis? P M examination

(Signed) Alexander Preston, M. D.

4/11, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	april 11 1930
20 UNDERTAKER Edward Bryan	ADDRESS 1671 orleans st

Spec.—6-9-19—R. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56081

CERTIFICATE OF DEATH.

100 E 56081

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) RESIDENCE. NO. 206 N. Bradford ST., 6-10 WARD

2-FULL NAME Hazel Smith

(a) RESIDENCE. NO. 206 N. Bradford ST., WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lester Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mabel Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

[redacted] Mabel Smith

(Address) 206 N. Bradford Ave

19 Registrar

2 1936

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1930

17 I HEREBY CERTIFY, That I attended deceased from April 6 1930, to April 11 1930, that I last saw her alive on April 9 1930, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm G Leyer Jr M. D.

19 (Address) 156 N. Melton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] DATE OF BURIAL 19 30

20 UNDERTAKER Edward Bryon ADDRESS [redacted]

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56082

CERTIFICATE OF DEATH

3/ E 56082

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 225 S. Ellwood Ave. WARD) 24

2—FULL NAME Edward H. Brown

(a) RESIDENCE NO. 225 S. Ellwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Connors Brown

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1871

7 AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
58	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager of

(b) General nature of industry, business, or establishment in which employed (or employer) Stewart Distilling Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Palmyre Warrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Catherine C. Brown

(Address) 225 S. Ellwood Ave.

15 Filed APR 12 1930, 19 ___ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/30

17 I HEREBY CERTIFY, That I attended deceased from 4/3, 1930, to 4/10, 1930, that I last saw h[illegible] alive on 4/10, 1930, and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

(Address) 633 S. Carlton

4/12 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL April 14 1930

20 UNDERTAKER John A. Moran

ADDRESS 3600 E. Balto

Spec.—8-16-29—L. F. S.—100 Bks.

235775
E 56083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

154-001
E 56083

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jean Higgins

(a) RESIDENCE NO. Auburn N. York ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Child

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	15 14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Auburn N.Y.

PARENTS

10 NAME OF FATHER Charles Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Ruth Stevenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 12 1930 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-11-1930

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 11, 1930, that I last saw her alive on April 11, 1930, and that death occurred, on the date stated above, at 7.35 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-9-30

Was there an autopsy? Yes.

What test confirmed diagnosis? X-ray.

(Signed) Edw. Bruce M. D.

4/12, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn N. Y.

DATE OF BURIAL 4/12 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56034 ✓ 188-103 E 56084

REGISTERED NO. E 56084

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph's Hosp St. 17-51 Ward)

2-FULL NAME Parbut Goodell

(a) RESIDENCE NO. 2539 Oak Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Col	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Apr 10 - 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	5 6		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Geo Gordon

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Alice Gordon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Eunice Page
(Address) 2539 Oak st

15 Filed APR 12 1930 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
boy ran into street & auto truck
truck wheel struck him
ac
(duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in front of 4332 Edmondson
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) J. Frame M. D.
4/12/30 (Address) 3939 W Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tye river Va	4/13 1930
20 UNDERTAKER Lottie Grose 1408	ADDRESS Ashland Va

IMPORTANT. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 56085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 154-001

REGISTERED NO. E 56085

2 35-927 56085

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanley Lewis Pittsburg Pa.

(a) RESIDENCE NO. 642 E. End Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4 1/2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) — Lot

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Foster Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Edith Holt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 Filed Apr 19 1930 CHAMPE S. JONES, M. D. Registrar

APR 12 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-12/30

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1930, to April 12, 1930 that I last saw h[illegible] alive on April 12, 1930 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus — congenital

Life (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 12-10-30

Was there an autopsy? yes

What test confirmed diagnosis? operation

(Signed) E. L. Compton, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md

DATE OF BURIAL Apr 13 1930

20 UNDERTAKER C. Mitchell & Sons

ADDRESS 1900 Eutaw pl.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56086 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56036

CERTIFICATE OF DEATH X 101-00

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. UNIVERSITY HOSPITAL ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME WALTER CANON

(a) RESIDENCE NO. 40 Pleasant ST., WARD

(Usual place of abode) Annapolis, Md. (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Lillian Canon

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Walter Cannon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Sarah Copeland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Walter Cannon (Address) Bridgeville Del

15 Filed 1 2 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 9th., 1930, to April 12th, 1930, that I last saw him alive on April 12th, 1930 and that death occurred, on the date stated above, at 5:00 A.m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Lobar - Right

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Nephritis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Physical Signs.

(Signed) Lewis P. Gundry, M. D.

(Address) University Hospital 4-12, 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bridgeville Del

DATE OF BURIAL April 13, 1930

20 UNDERTAKER L L Brown

ADDRESS 109 N. Main

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56087 E 56087

CERTIFICATE OF DEATH

34

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Lyndhurst Hospital ST. (16-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles F. Owen

(a) RESIDENCE NO. 2859 Prospect ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) boy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Daniel V. Owen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Isabel Wilhelm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Daniel Owen

(Address) 2859 Prospect St.

15 Filed ..., 19... C. HAMILTON ORRIS, M. D. Registrar

R 13 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1930, to April 12, 1930,

that I last saw him alive on April 12, 1930,

and that death occurred, on the date stated above, at 10 15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis

(Meningococcus)

(duration) ... yrs. ... mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Myron S. Zell, M. D.

4/12, 1930 (Address) Lyndhurst Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 4/14/1930

20 UNDERTAKER Gaither & Son 2503 Edmondson

ADDRESS

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56088 92 E 56088

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Warren L. Seipp

(a) RESIDENCE NO. 411 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Minnie C. Seipp

6 DATE OF BIRTH (month, day, and year) 2/21/1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker 46

(b) General nature of industry, business, or establishment in which employed (or employer) Title Gu T Co

(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Seipp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Todhunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elizabeth Perry

(Address) 411 Roland Ave

15 PR 12 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to April 11, 1930,

that I last saw him alive on April 11, 1930

and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. H. Varney, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill (Towson)

DATE OF BURIAL 4/14/1930

20 UNDERTAKER B. Wm Cook

ADDRESS 1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56089

CERTIFICATE OF DEATH

49 E 56039

REGISTERED NO.

1—PLACE OF DEATH The Church Home & Infirmary

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. N. Broadway ST., 9-46 (WARD)

2—FULL NAME Captain J. William Cullison

(a) RESIDENCE NO. 1910 East 31st Street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elnora Cullison

6 DATE OF BIRTH (month, day, and year) 12/16/1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sea Captain

(b) General nature of industry, business, or establishment in which employed (or employer) A. H. Bull & Co

(c) Name of employer Balto Md

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Benj. Cullison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elnora Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elnora Cullison

(Address) 1910 E. 31st st

15 Filed APR 13 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/30

17 I HEREBY CERTIFY, That I attended deceased from 4/8/30, 19..., to 4/12/30 19..., that I last saw h.im alive on 4/12/30, 19..., and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

Sarcomatosis (Melanotic) the primary origin of which was not able to be ascertained

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4/8/30

Was there an autopsy? No

What test confirmed diagnosis? operation & section studied microscopically.

(Signed) J. Frank Hewitt, M. D.

4/12, 1930 (Address) The Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 4/15/1930

20 UNDERTAKER Wm Cook 1217 ADDRESS St Paul St

Cor.—10-10-29—A Co.—100 Bks.

E 56090

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56090

CERTIFICATE OF DEATH

89

REGISTERED NO. 28-63

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4405 Gronland St., Ward)

2-FULL NAME Arnold F. Ritte

(a) RESIDENCE NO. 4405 Gronland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Minnie

6 DATE OF BIRTH (month, day and year) Feb 9-1871

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or .... min.
	59	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Master Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) 69
(r) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo. Ritte

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Arnold F. Ritte
(Address) 4405 Gronland

Registrar

APR 12 1930 HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris
Sudden
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) H. Hamilton Jones, M. D.
(Address) 1217 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	4/14/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Certificate. ... important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56091 131 E 56091

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 3-4 WARD)

2-FULL NAME Lena May

(a) RESIDENCE NO. 1426 E. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Lawson.

6 DATE OF BIRTH (month, day, and year) 3-2-60

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed ..... 19 ..... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-9-30

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1930, to 4-9, 1930, that I last saw h[illegible] alive on 4-9, 1930, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pyonephrosis - Bilateral

(duration) 4 yrs. [illegible] mos. [illegible] da.

CONTRIBUTORY (Secondary) Pulmonary Infarct

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

4-12, 1930 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 4/13 1930

20 UNDERTAKER Jno J. Fahey Sons

ADDRESS 1318 Light St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56092

CERTIFICATE OF DEATH

33 E 56092

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 11-74 Ward)

2-FULL NAME Wm Eugene H. Jayes

(a) RESIDENCE NO. 1031 Druid Hill Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day, and year) June 25 1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	29	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Elevator Operator
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Jacob Jayes

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Yancy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Sarah Yancy
(Address) 1031 Druid Hill Ave

15 Filed 19 G. HAMPSON JONES, M. D. Registrar
DEC 1 3 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Bowel

(duration) yrs. 6 mos. — da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Hedrick M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	12/12 1930
20 UNDERTAKER Samuel I. Hemsley	ADDRESS 578 N Bdle

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be

Cor.—10-10-29—A Co.—190 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 56093 — 107-001 — E 56093

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St. 17-24 Ward)

2-FULL NAME Jas Shaw

(a) RESIDENCE NO. 902 Penn Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs or min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: U. C.

9 BIRTHPLACE (city or town) (State or country): Baton Rouge La

PARENTS

10 NAME OF FATHER: Baton Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. S.

12 MAIDEN NAME OF MOTHER: Julia Dotson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. S.

14 Informant (Address): Nathaniel Harris 1506 Pennsylvania Ave

15 Filed ... 19... Registrar: C. HAMPSON JONES, M.D. Regt.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and hour) Nov 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Coroner, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Duration: yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. W. Funk M. D.

(Address) 1524 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem

DATE OF BURIAL: Nov 13 1930

UNDERTAKER: Robert S Williams

ADDRESS: 1515 W Baltimore St

OF DEATH is plain terms, so that it may be properly important. See instructions on back of certificate.

RECEIVED NOV 13 1930

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56094

CERTIFICATE OF DEATH.

3/ E 56094

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Mc Henry ST. 14-28 WARD)

2-FULL NAME EVA Cukas Or Teukas

(a) RESIDENCE No. 1421 Mc Henry ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. - mos. ds. How long in U. S., if of foreign birth? 17 yrs. - mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vicent Cukas

6 DATE OF BIRTH (month, day, and year) No 1899

7 AGE 40	Years	Months	Days	If LESS than 1 day, hrs or min.
	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Litvania

PARENTS

10 NAME OF FATHER Andrus Klimas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Litvania

12 MAIDEN NAME OF MOTHER Agnes Daltuas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Litvania

14 Informant Vicent Cukas (Address) 1421 Mc Henry Street

15 Filed 4-9-1930. C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 11, 1930. that I last saw her alive on April 10, 1930. and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

4/12 1930 (Signed) Wm O'neill M. D. (Address) 108 N Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: April 14, 1930

20 UNDERTAKER: John Greblianckas — ADDRESS: F. G. 423 S Paca St

Size—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56095 ✓ 25-001 E 56095

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. (Ward) 17-24

2-FULL NAME Lucy Hall

(a) RESIDENCE NO. 528 Hanover ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if at foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record (Address)

15 Filed R 1 3 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11-30

17 I HEREBY CERTIFY, That I attended deceased from 5-25, 1928, to 4-11, 1930, that I last saw h[illegible] alive on 4-11, 1930, and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

Generalized Arteriosclerosis

Right Hemaplegia

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Lumpkin, M. D.

4-12, 1930 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

20 UNDERTAKER Arnold Easton

DATE OF BURIAL 4-13 1930

ADDRESS 916 Ga ave.

Spec.—1-15-23—M&T—500 Blks.

E 56096

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56096

31

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1.-PLACE OF DEATH

CITY OF BALTIMORE: (a) NO. 225 N. Vincent st. 14-27 WARD)

2.-FULL NAME Arthur Oden

(a) RESIDENCE NO. 225 N. Vincent st. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Abt 15 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lessie Oden.

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	38	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lab.

(b) General nature of industry, business, or establishment in which employed (or employer): Meat Packing.

(c) Name of employer: Cockerin Hill Co. Harmond, Md.

9 BIRTHPLACE (City or town) (State or country): Martin Oden

PARENTS

10 NAME OF FATHER: Martin Oden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Price Georges, Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Lessie Oden

(Address): 225 N. Vincent St.

15 Filed APR 13 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-11- 19 30

17 I HEREBY CERTIFY, That I attended deceased from April 8th, 19 30, to April 11th. 19 30, that I last saw h im alive on April 11th. 1930 and that death occurred, on the date stated above, at 1.00 p m

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.
Fulminating type.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harmons Md

DATE OF BURIAL: 4-13 1930

20 UNDERTAKER: Dent Easton

ADDRESS 916 Pa Ave

APR 13 1930 HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 56097 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3602 Paine ST. 13-52 WARD) REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Magdalena Armstrong

(a) RESIDENCE NO. 3602 Paine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A Armstrong

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant John L Armstrong (Address)

15 Filed 1930 G H Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-30

17 I HEREBY CERTIFY, That I attended deceased from 3-1, 1930, to 4-10, 1930, that I last saw her alive on 4-10, 1930, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J N Wilson, M. D.

, 19 (Address) 848 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL 4/14, 1930

20 UNDERTAKER John Ulrich — ADDRESS 2008 Orleans

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56098

E 56098

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 835 S. Bond St. St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Of Paul & Wladyslawa Kempa

(a) RESIDENCE NO. 835 S. Bond St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12 1930

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Paul Kempa

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Wladyslawa Grabowska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Paul Kempa

(Address) 835 S. Bond St.

15 Filed APR 13 1930 Registrar

HARRISON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest, aforesaid Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia Neon.

Broken Compression

Duration: ___ yrs. ___ mos. 2d ds.

CONTRIBUTORY (Secondary) (Duration) ___ yrs. ___ mos. ___ ds.

4/13/30 (Signed) J C Blades M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary April 13 1930

Date of Burial

20 UNDERTAKER John M Walsh

ADDRESS 12 E Chester

Spec.—1-10-21—M&T—1500 Blks.

56099

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56099

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Howard Kelly Hospital

CITY OF BALTIMORE: (No.) 1418 Eutaw Place St. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Michael Seligman

(a) RESIDENCE NO. ~~1418~~ ST., WARD Anderson S.C.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Phillips

6 DATE OF BIRTH (month, day, and year) March 7th 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32 years	0 mos	3 days	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dental student

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Anderson S. C.

PARENTS

10 NAME OF FATHER Mr Martin Seligman

11 BIRTHPLACE OF FATHER (city or town) Berlin (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Kissel

13 BIRTHPLACE OF MOTHER (city or town) Anderson (State or country) S. C.

14 Informant Mrs Martin Seligman (Address) Anderson S. C.

15 Filed APR 13 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10th, 1930, to April 13th, 1930, that I last saw h~~e~~r alive on April 13th, 1930 and that death occurred, on the date stated above, at 9 00 a m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) 1 yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Secondary Anaemia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Anderson S. C.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy

(Signed) Curtis L Burrus M. D.

. 19 (Address) H C Kelly Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Anderson, S.C

DATE OF BURIAL 4/13/1930

20 UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt Royal Ave

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56100

CERTIFICATE OF DEATH.

129 E 56100

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1954 Perlman Place ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Gauley

(a) RESIDENCE NO. 1954 Perlman Place ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Gauley.

6 DATE OF BIRTH (month, day, and year) Dec. 6 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
53	54	7 4	2 3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Balzius Meister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hanora Allan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas J. Gauley (Address) 1954 Perlman Place

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9/30

17 I HEREBY CERTIFY, That I attended deceased from March 11 1930 to April 9 1930

that I last saw h[illegible] alive on April 9 1930

and that death occurred, on the date stated above, at 9 15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Mitral Insufficiency

(duration) 1 yrs. mos da.

CONTRIBUTORY (Secondary) Uremia & Coma (duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination & Urinalysis

(Signed) Albert Casullo M. D.

4/10. 1930 (Address) 2025 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL April 14th 1930

20 UNDERTAKER Lilly & Julian Inc

ADDRESS 403 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56101

CERTIFICATE OF DEATH

129 E 56101

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3218 Foster ave ST., 76-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Hoffman

(a) RESIDENCE NO. 3218 Foster ave ST., 24 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Hoffman

6 DATE OF BIRTH (month, day, and year) Dec 17-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
67 68	3	24	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home. D 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christian Hoffman

(Address) 3218 Foster ave, Baltimore

15 Filed APR 13 1930 [illegible] Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-10-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1930, to April 10, 1930, that I last saw h~~er~~ alive on April 10, 1930, and that death occurred, on the date stated above, at 8 53 ~~PM~~ AM. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Chronic Nephritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. Stanley, M. D.

, 19 (Address) 800 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Hearts Cemt.

DATE OF BURIAL April 14 1930

20 UNDERTAKER D. Lilly & Zeiler

ADDRESS 453 Gilmor St.

Spec.—1-10-21—M&T—1500 Blks.

E 56102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56102

REGISTERED NO. 179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 19-38 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Fuhrer

(a) RESIDENCE NO. 1823 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 23-1891

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
38	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elias Fuhrer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs E. Browning 1823 Frederick Ave

15 Filed 3.1930 C. HARRISON JONES, M. D. Registrar

By Kelly

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11 1930

17 I HEREBY CERTIFY, That I attended deceased from 3-22 .1930. to 4-11 .1930.

that I last saw her alive on 4-11 .1930.

and that death occurred, on the date stated above, at 10.50 a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brenner M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Apr. 14 1930

20 UNDERTAKER George L. Schwab ADDRESS 201 Park Ave.

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56103

CERTIFICATE OF DEATH.

90 E 56103

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital 4-20 WARD)

2-FULL NAME Mrs. Jennie O'Neill

(a) RESIDENCE NO. 2014. Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank O'Neill

6 DATE OF BIRTH (month, day, and year) March 25, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oswego, New York

PARENTS

10 NAME OF FATHER William Firth

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Catherine Hamper (Address) 432 E 22 St, Balto Md

15 Filed APR 13 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-3 1930 to 4-11 1930,

that I last saw her alive on 4-11 1930,

and that death occurred, on the date stated above, at 1. A. m.

The CAUSE OF DEATH* was as follows:

Severe Myocarditis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) ..... M. D.

19 (Address) 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	4/14/30 19
UNDERTAKER	ADDRESS
L. Vernon Lemmon	4513 Park Heights Ave.

THION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

✓ E56104

235931 E56104

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 100-001

REGISTERED NO. [redacted]

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Betty Ellen Whittle

(a) RESIDENCE NO. Joppa Rd + Ridgely Ave ST. WARD
(Usual place of abode) Towson, Md (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28-1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2½	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Whittle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Stuart

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 Filed [illegible] 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13-30

17 I HEREBY CERTIFY, That I attended deceased from 4-11, 1930, to 4-13, 1930, that I last saw h er alive on April 13, 1930 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, diffuse, Bilateral

4-7 days
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Bickford, M. D.

4/13, 1930 (Address) J H H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL April 15 1930

20 UNDERTAKER Frederick Loeb & Sons

ADDRESS Fullerton

Spec.—2-29-28—L. F. S.—500 Blks.

E 56105

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56105

CERTIFICATE OF DEATH

129

E 56105

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 N. Eden ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert H. Harris

(a) RESIDENCE NO. 403 N. Eden ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of: Maggie C. Harris

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 60 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John P. Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Bernard Harris

(Address): 31 - S. Carlin St

15 Filed APR 14 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-11-30

17 I HEREBY CERTIFY, That I attended deceased from 3-5, 1930, to 4-11, 1930, that I last saw h— alive on 4-10, 1930 and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular-Renal Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of —

Was there an autopsy? no Clinical

What test confirmed diagnosis?

(Signed) W. B. Butler, M. D.

, 19 (Address) 425 N. Carline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Gem

DATE OF BURIAL: 4-14th 1930

20 UNDERTAKER: Jas. M. Skinner

ADDRESS: 1625 E. Lond St

Spec. 1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56106

CERTIFICATE OF DEATH.

90 E 56106

REGISTERED NO.

1-PLACE OF DEATH Balto. City Hospitals

CITY OF BALTIMORE: (No. ... St. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Roberts

(a) RESIDENCE NO. 1601 Laurens ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Sept. 11, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Thos. Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Macy Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of
(Address) Balto. City Hosp.

15 Filed 4 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11-30

17 I HEREBY CERTIFY, That I attended deceased from 2-8-30, 19..., to 4-11-30, 19..., that I last saw him alive on 4-11-30, 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

1. Myocarditis, Chronic

(duration) over 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over 3 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas H. Wilson, M. D.

4-12, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portsmouth Va	4-15 1930
20 UNDERTAKER	ADDRESS
Joseph A Lively	409 N Mount St

HAMPSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56107

CERTIFICATE OF DEATH

E 56107

REGISTERED NO.

(if death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hosp St., Ward)

2-FULL NAME Otwin Kurpisz

(a) RESIDENCE NO. 2005 Eastern Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-11-1926

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John Kurpisz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Manek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant John Kurpisz
(Address) 2005 Eastern Ave

15 Filed ..... 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Child ran over by rear wheels of truck and apparently he was trying to catch on to it (duration) Fract Skull C. C.

CONTRIBUTORY (Secondary)
ac. (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Fleet & Castle

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. V. Frame M. D.

4/12 1930 (Address) 2439 Mc Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem. Balto	14th April 1930
20 UNDERTAKER D. W. Grzesnicki	ADDRESS Eastern Ave

Important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

E 56108 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56108

CERTIFICATE OF DEATH

1-PLACE OF DEATH Rev. Joseph Hendrick C. SS. R. 129

CITY OF BALTIMORE: (NO) St Joseph's Hospital ST. 10-14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Father Joseph Hendricks

(a) RESIDENCE NO. St James Rectory ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs — mos — ds. How long in U. S., if of foreign birth? Life yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [redacted] 13 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	1	—	

8 OCCUPATION OF DECEDENT
(a) Trade, profession or particular kind of work: Redemptorist Priest
(b) General nature of industry, business, or establishment in which employed (or employer): Clergy
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Information at St. James Rectory
(Address) 1225 E Eager St

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-13- , 1930 , to 4-13- , 1930, that I last saw h[illegible]live on 4-13 , 1930 and that death occurred, on the date stated above, at 8 25 A m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs mos. ½ ds.

18 Where was disease contracted if not at place of death? at rectory

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) W. F. Lundy , M. D.

4/13 1930 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Apr. 16 1930

20 UNDERTAKER: Henry Hoeck Sons Inc. — ADDRESS: 1801 E Eager St

THION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

E 56109

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital (ST.) 9-46 (WARD)

REGISTERED NO. 51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emily P. Albrecht

(a) RESIDENCE NO. 2630 Robb ST. WARD

(Usual place of abode) (If non-resident give City or town and State)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (or) WIFE of George A. Albrecht.

6 DATE OF BIRTH (month, day, and year) Dec. 21 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Richard P. Spalding

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Margaret Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr. Geo. A. Albrecht. (Address) 2630 Robb St.

15 Filed APR 14 1930 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 13 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-11-30, 19, to 4-13, 1930, that I last saw her alive on 4-13-30, 19, and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus (acidosis) with pneumonia.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) M B Kinney, M. D.

, 19 (Address) 1 W Lanvale, Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Apr. 15 1930

20 UNDERTAKER: Henry Wolf Sons Inc. — ADDRESS: 1301 E Eager St

IMPORTANT—See instructions on back of certificates. INFORMATION is very important.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56110

CERTIFICATE OF DEATH.

90 E 56110

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Plymouth Stall Apts 14-20 St. _____ Ward)

2-FULL NAME Bertie Ann Rogers

(a) RESIDENCE NO. Plymouth Stall Apts St. _____ Ward _____
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 58 yrs. 5 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 Color or Race White | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles A. Rogers

6 DATE OF BIRTH (month, day, and year) October 22 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	58	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Carrollton.

(State or country) Maryland.

PARENTS

10 NAME OF FATHER James Wirt

11 BIRTHPLACE OF FATHER (city or town) Carrollton

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Gebhardt

13 BIRTHPLACE OF MOTHER (city or town) Carrollton

(State or country) Maryland.

14 Informant Mrs Ann S. Rogers (daughter)

(Address) Plymouth Stall Apts

15 Filed APR 4 1930 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest and inquiry found that said deceased came to her death (Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis.

Duration yrs. 1 mos. ____ ds.

CONTRIBUTORY (Secondary) Broken Long Sinusitis

Duration yrs. ____ mos. 1 ds.

Apr 13 30 Signed G C B Yates M. D.

(Coroner)

19 (Address) 1437 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery Date of Burial Apr 15 1930

20 UNDERTAKER Edward H Conner Co ADDRESS 10 Dulaney Pl

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 56111

CERTIFICATE OF DEATH

E 56111

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3012 Kenwick Road St.) (43-52 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther Mann Rinehart

(a) RESIDENCE NO. 3012 Kenwick Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6½ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Mar 7, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
		1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER George Rinehart

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Mann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant George Rinehart

(Address) 3012 Kenwick Road

15 Filed APR 14 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 12, 1930,

that I last saw her alive on April 12, 1930

and that death occurred, on the date stated above, at 2:30 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity (6½ mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. C. Cliff, M. D.

Apr 13, 1930 (Address) 3532 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	Apr 14 19 30
20 UNDERTAKER	ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56112

CERTIFICATE OF DEATH

E 56112

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital St. 11-24 (Ward)

2-FULL NAME Emma Stansbury

(a) RESIDENCE NO. 1120 Linden St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Morgan

6 DATE OF BIRTH (month, day and year) Feb 18 - 1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	36	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Alfred Pitchett

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Louise Bowen
(Address) 1120 Linden Ave

15 Filed [illegible] 19 [illegible] Registrar

R 14 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 10 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest find that said deceased came to her death (Inquest, autopsy or inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Pelvic Abcess

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 30

Was there an autopsy? Yes

What was confirmed diagnosis? Autopsy

(Signed) C. E. Glades, M. D.

19 (Address) 316 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	5/1/1930
20 UNDERTAKER	ADDRESS
Mrs. Geo. H. Holland	16 E Dundalk

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56113

CERTIFICATE OF DEATH

74-001

E 56113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (Corner 900 Block Fulton Ave 16 Ward)

2-FULL NAME Richard C. Spencer

(a) RESIDENCE NO. 813 W. Bruce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma

6 DATE OF BIRTH (month, day, and year): July 10 1872

7 AGE: Years 37 Months 8 Days 24 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 0
(c) Name of employer:

9 BIRTHPLACE (city or town): Trenton
(State or country): N. J.

PARENTS

10 NAME OF FATHER: Jacob Spencer

11 BIRTHPLACE OF FATHER (city or town): Pa
(State or country):

12 MAIDEN NAME OF MOTHER: Emma Davis

13 BIRTHPLACE OF MOTHER (city or town): Pa
(State or country):

14 Informant: Emma Spencer
(Address): 726 Fairmount

15 Filed 1-4 1936 HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Jan 1 1936

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Sudden

(duration) yrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) F. C. Smith M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: Jan 4 1936

20 UNDERTAKER: Sam'l H. Chase Son

ADDRESS: 1401 W. Pratt

Please print items, as data is most important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56114 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 56114

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2406 McElderry ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel May Burton

(a) RESIDENCE NO. 2406 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 3-1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Howard Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anne McFall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Emma L. Burton

(Address) 2406 McElderry St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11-1930

17 I HEREBY CERTIFY, That I attended deceased from 1923, 19..., to Apr 11, 1930, that I last saw her alive on Apr 11, 19 30 and that death occurred, on the date stated above, at Apr 11 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis 7 years

(duration) ...yrs...mos...da.

CONTRIBUTORY (Secondary)

(duration) ...yrs...mos...da.

18 Where was disease rontracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. D. Wheeton, M. D.

, 19 (Address) 4309 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL April 14 1930

20 UNDERTAKER Wm. C. Miller & Son

ADDRESS 2324 Jefferson St.

C. HAMPSON JONES, M. D.
APR 14 1930

Spec.–7-17-26–A Co.–200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 E 56115

REGISTERED NO.

E 56115

1-PLACE OF DEATH

City of BALTIMORE (No.) 1912 Mckean Ave (St.) (15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Koppel

(a) RESIDENCE NO. 1912 McKean Ave Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Oscar Koppel

6 DATE OF BIRTH (month, day, and year): Nov 3 1871

7 AGE — Years: 58 Months: 4 Days: 13

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER: Abraham Stern

11 BIRTHPLACE OF FATHER (City or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Sara Seferer

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country)

14 Informant: Robert Stern

(Address): 1912 McKean Ave

15 Filed 4-14 1930 HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 4/12/30

17 I HEREBY CERTIFY, That I attended deceased from Mch 19 29, to 4/12/30,

that I last saw her alive on 4/12/30, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer Suprina Maxillary

Duration (duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(ducation) yrs. mos. 6 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) H T S Lon, M. D.

4/13, 19 30 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cemetery Date of Burial 4/15/30

20 UNDERTAKER: J. Ahrens & Co. ADDRESS 2432 Pulaski Hwy

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56116

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56116

CERTIFICATE OF DEATH.

REGISTERED NO. 32

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 2-4 ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Gammerman

(a) RESIDENCE NO. 16 S. Ann St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 8 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Israel Gammerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anne Lerner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Israel Gammerman
(Address) 16 S. Ann St

15 Filed 4-14-30, 19... at ..... C. THAMPSON JONES, M. D. Registrar

14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/30

17 I HEREBY CERTIFY, That I attended deceased from 4/4, 1930, to 4/11, 1930, that I last saw her alive on 4/11, 1930, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) ..... yrs. ..... mos 15 ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) B. J. Cahen M. D.

..... 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 4/14 1930

20 UNDERTAKER Jack Levin

ADDRESS 1434 Bals St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56117

CERTIFICATE OF DEATH.

57 ✓ E 56117
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 E. Preston St. 8-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bridget Chaffman

(a) RESIDENCE No. 2109 E. Preston St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David H Chaffman

6 DATE OF BIRTH (month, day, and year) Feb. 2-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	2	9.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Crilley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant David H Chaffman
(Address) 2109 E. Preston St.

15 Filed ___ No. ___ Registrar ___

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1930

17 I HEREBY CERTIFY, That I attended deceased from April 8 1930 to April 11 1930, that I last saw her alive on April 11 1930, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 2 yrs. ___ mos ___ ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) ___ yrs. ___ mos. 3 ds.

18 Where was disease contracted if not at place of death? ___

Did an operation precede death? No Date of ___

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory tests

(Signed) Hugh Singenday M. D.

4/13 1930 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Apr 15 1930
20 UNDERTAKER	ADDRESS
Geo M. Enis & Son	811 N Wolfe

C. HARRISON JONES, M. D.

Spec.—1-10-21—M&T—1500 Blks.

E 56118

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ E 56118

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hosp ST. 15-61 WARD)

2-FULL NAME Conrad Schott.

(a) RESIDENCE NO. 2302 Garrison Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Eva Schott.

6 DATE OF BIRTH (month, day and year): Sept 21 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): ? 066

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Schott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary R. Schroder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hosp. Records

15 Filed 4 1930 . 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-12-30

17

I HEREBY CERTIFY, That I attended deceased from 4-2-30 . 19 . to 4-12-30 19 .

that I last saw him alive on 4-12-30 19 .

and that death occurred, on the date stated above, at 3 40 P. m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-Vascular Disease.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Congestive Heart Failure

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thos Shuttleworth M. D.

(Address) 20 W. Mt. Royal Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: April 15 1930

20 UNDERTAKER: John O. Mitchell

ADDRESS: 1900 Eutaw Place

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—MAT—500 Blks.

E 56119 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56119

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH Sinai Hospital REGISTERED NO. 6468

CITY OF BALTIMORE: (No.) 1000 Caton Ave ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Butler

(a) RESIDENCE NO. 1421 Poplar Grove ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aug 1. 1839

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	90	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ellicott City Md

PARENTS

10 NAME OF FATHER John Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ann Langhlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sinai Hospital

(Address) Frances E. Butler, Poplar Grove

15 Filed 19 Registrar

C. THOMPSON SMITH, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Nov- 19, 1925, to April 12, 1930,

that I last saw her alive on April 12, 1930,

and that death occurred, on the date stated above, at 3-25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage bronchopneumonia mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apl 15 19 30
20 UNDERTAKER John O. Mitchell & Sons	ADDRESS Eutaw Place

Spec. 8-16-29—1. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 35891
E 56120

CERTIFICATE OF DEATH X 159-001 E 56120

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jean Norma Osterhof

(a) RESIDENCE NO. Dover New Jersey ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12-1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work add

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N J.

PARENTS

10 NAME OF FATHER Arthur

11 BIRTHPLACE OF FATHER (city or town) Ill (State or country)

12 MAIDEN NAME OF MOTHER Vera True

13 BIRTHPLACE OF MOTHER (city or town) Ind (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12-1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 12, 1930, that I last saw her alive on April 12, 1930 and that death occurred, on the date stated above, at 10 35 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 2 mos. 2d ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4-12-30

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cem.

DATE OF BURIAL 4/15 1930

20 UNDERTAKER John O. Mitchell & Son

ADDRESS 1900 Eutaw Place

Spec.—12-8-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00 E 56121

CERTIFICATE OF DEATH.

E 56121

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2536 West Fayette Street 20-69 Ward)

2-FULL NAME Franzeska Nehls

(a) RESIDENCE NO. 2536 W. Fayette St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Theodore Nehls

6 DATE OF BIRTH (month, day, and year): March 16th, 1848

7 AGE: Years 82; Months ----; Days 28 27; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ----------

(c) Name of employer: ----------

9 BIRTHPLACE (city or town)

(State or country): Russia

PARENTS

10 NAME OF FATHER: Adam Sprung

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Russia

14 Informant (Address): Mrs Max Oelmann 2536 W. Fayette St

15 Rec. [illegible] M. D. Registrar

4 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13th 30.

17 I HEREBY CERTIFY, That I attended deceased from 4/1- 1930, to 4/13- 1930

that I last saw h[illegible] alive on 4/13 1930

and that death occurred, on the date stated above, at 11.30 m AM.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Gangrene Right Foot & Hand

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death!

Did an operation precede death! No Date of

Was there an autopsy! No

What test confirmed diagnosis! Blood Pressure

(Signed) Chas A Cohn, M. D.

4/14 1930 (Address) 2145 N Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

Date of Burial: Apr. 16 1930

20 UNDERTAKER: F. B. Wippert, 1850 W. Baltimore St.

ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 E 56122

E 56122

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) 509 Oakland Ave ST. 27-46 WARD)

2—FULL NAME Fredericka Drechsler

(a) RESIDENCE NO. 509 Oakland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs 10 mos 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced: HUSBAND of (or) WIFE of: Augusta F. Drechsler

6 DATE OF BIRTH (month, day, and year): May 23rd 1862

7 AGE: Years 67 | Months 10 | Days 19 | If LESS than 1 day, hrs or min. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: John Drechsler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Wensel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Augusta F. Drechsler

(Address) 509 Oakland Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11th 30

17 I HEREBY CERTIFY, That I attended deceased from April 5th 19 29 to April 11 19 30

that I last saw him alive on April 11 19 30

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris (1 hour)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis etc.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of? —

Was there an autopsy? —

What (test confirmed diagnosis): —

(Signed) Hattie E Kuchman M. D.

4/12, 19 (Address) 2002 N. Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 4/14/19 30

20 UNDERTAKER: F. A. Wehrheit

ADDRESS: 150 N. Bethel St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56123 48 E 56123

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 N Bolton ST. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chas Weyer

(a) RESIDENCE NO. 1809 N. Bolton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 95 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced: HUSBAND of (or) WIFE of Louise Weyer

6 DATE OF BIRTH (month, day, and year): May 15th 1834

7 AGE: Years 95 | Months 11 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fred'k Weyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louis Gregory E. Weyer

(Address) 1809 N. Bolton St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 11th 1930 to April 11 1930.

that I last saw him alive on April 11th 1930 and that death occurred, on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Epithelioma of face.

Senile asthenia.

Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ethelbert Henning, M. D.

4/13, 1930 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: April 14, 1930

20 UNDERTAKER: J. B. Keyser

ADDRESS: 1850 N. Bolton St

THOMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 56124 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56124

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH: Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 7-11 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: John J. Kelly

(a) RESIDENCE NO. 530 W. Ellwood Ave. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: -

6 DATE OF BIRTH (month, day, and year): April 6, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62		6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS
10 NAME OF FATHER: Patrick Kelly
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland
12 MAIDEN NAME OF MOTHER: Ellen ?
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Records of Balto. City Hosp.

Filed 4 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-12-30

17 I HEREBY CERTIFY, That I attended deceased from 4-8-30, 19..., to 4-12-30, 19...,
that I last saw h in alive on 4-12-30, 19...,
and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:
Myocarditis, chronic

(duration) ... yrs. over 1 mos ... ds.

CONTRIBUTORY (Secondary): Carcinoma of stomach suspected
(duration) ... yrs. over mos. 8 ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Harvey W. McKean, M. D.
4-12 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Cathedral — DATE OF BURIAL: 4-15 1930

20 UNDERTAKER: Fredk R. Cole — ADDRESS: 1200 W. Lombard St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56125

74-001

E 56125

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2236 E. Biddle St. 8-12 Ward)

2-FULL NAME Charles A. Carmine

(a) RESIDENCE NO. 2236 E. Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Mary E. Carmine

6 DATE OF BIRTH (month, day, and year) June 6/1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65	10	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Harness maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER James Carmine

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Francis Hubbard

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mary E. Carmine
(Address) 2236 E. Biddle St

Filed ..... 19 ..... Registrar

1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

1/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL Jan 15 1930

20 UNDERTAKER Philip Herwig

ADDRESS 3076 Eastern Ave

A CERTIFICATE OF DEATH is prima facie evidence only, so that it may be proved incorrect, but it is important that it should be correct. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56126

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56126

CERTIFICATE OF DEATH.

REGISTERED NO. 74

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1313 Madison Ave ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nelson L. Groome

(a) RESIDENCE NO. 1313 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Birth yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Nelson Groome

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Lewis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Laura Higgins
(Address) 1313 Madison Ave

15 Filed ..... 19 ..... HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11-30

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to April 11, 1930, that I last saw him alive on April 11, 1930, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Pneumonia

(duration) 2 yrs. mos 0 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) H. C. B. Hare, M. D.

19 1930 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL 4/14 1930

20 UNDERTAKER Edmund C. Hensley

ADDRESS 578 N. Bond

Spec.—1-12-23—MAT—500 Blks.

E 56127 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56127

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1907 Ethel St. 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celexander Brown

(a) RESIDENCE NO. 1907 Ethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 65 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Brown

(Address)

15 Filed APR 14 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April-11-1930

17 I HEREBY CERTIFY, That I attended deceased from April-6, 1930, to April-11, 1930.

that I last saw him alive on April-10, 1930

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) W. J. Coleman M. D.

(Address) 2037 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	4-14-30

20 UNDERTAKER: Paul F. Kenny ADDRESS 578 Eutaw St

21

Spec.—1-30—M. & T.—250 Bks.

E 56128 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56128

43

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 18-76 WARD)

2-FULL NAME Mr Henry Sutton

(a) RESIDENCE NO. 736 W. Saratoga ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor 070
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lloyd Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mary land

12 MAIDEN NAME OF MOTHER Sophia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mary land

14 Informant Hospital Record
(Address)

15 Filed APR 4 1930, 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11-30

17 I HEREBY CERTIFY, That I attended deceased from 1-31, 1930, to 4-11, 1930,
that I last saw h.. alive on 4-11, 1930,
and that death occurred, on the date stated above, at 9 A.M. P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma Mouth
(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchis pneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Lt. Lumpkin, M. D.
4-12 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.
DATE OF BURIAL 4/4 1930

20 UNDERTAKER Samuel T. Hawsley
ADDRESS 776 McCulloh

Cor.—12-9-25—A Co.—200 Bks.

E 56129

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56129

CERTIFICATE OF DEATH.

181-001

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2813 Odonnell St. 1-1 Ward)

2-FULL NAME Thomas (Thom) Hoopa

(a) RESIDENCE NO. 2813 Odonnell St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 20 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widower.

6 DATE OF BIRTH (month, day, and year): Nov. 29 - 1886

7 AGE — Years: 43 — Months: 4 — Days: 13 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Balto Copper Works.

9 BIRTHPLACE (city or town): _____
(State or country): Poland

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town): _____
(State or country): Poland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town): _____
(State or country): Poland

14 Informant: Frank Hoopa
(Address): 2808 Gough

15 Filed _____ 19____ _____ Registrar

4 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:*

Accidental Gas Poisoning Ill.
(Duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Asphyxia
(Duration) ___ yrs. ___ mos. ___ ds.

Apr 30 (Signed) C. E. Gradus M. D.
(Coroner)

14 , 19 (Address) 1430 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death..... yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Kostka — Date of Burial: April 15 1930

20 UNDERTAKER: Stephen J. Fiatkowski Inc — ADDRESS: 1000 N. Kenwood ave

Spec.—1-30—M. & T.—250 Bks.

Crown

E 56130

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56130

CERTIFICATE OF DEATH.

89

REGISTERED NO. 13-59

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Druid Park ST. or WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Crown

(a) RESIDENCE NO. 2322 Druid Park ST. or WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanley R. Crown

6 DATE OF BIRTH (month, day, and year) May 17 - 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	10.	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Amanders Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Susie Eck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Stanley R. Crown

(Address) 2322 Druid Park Drive

15 Filed APR 14 1930 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12/1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 7, 1930, to Apr 12, 1930, that I last saw h alive on Apr 11, 1930, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H S Jones, M. D.

April 14, 1930 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL April 14 1930

20 UNDERTAKER Josiah Syfer ADDRESS 1600 N. Gay St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56131 — REGISTERED NO. E 56131

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4910 Holder Ave ST. 27-42 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W. Sindall

(a) RESIDENCE NO. 4910 Holder Ave. ST. WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William F. Sindall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Richard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Ella M. Sindall
(Address) 4910 Holder ave.

15 Filed Apr 14 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to April 11, 1930

that I last saw h[e] alive on April 13, 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hypostasis

Bronchial pneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Smith, M. D.

Apr 14 1930 (Address) 4706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem.	Apr. 14 1930

20 UNDERTAKER Wm C. Black ADDRESS 927 N. Broadway

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56132 129 E 56132

1—PLACE OF DEATH

REGISTERED NO. 1465

(If death occurred in hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 231 South Fulton Avenue) (Ward)

2—FULL NAME Elmer Clunk

(a) RESIDENCE NO. 231 South Fulton Avenue
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug 22 nd 1895

7 AGE: Years 34 — Months 7 — Days 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Builder

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Geo. L. Clunk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Cecilia Mc. Kin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kentucky

14 Informant: Frances Clunk

(Address): 231 S. Fulton Ave

15 Filed 1 4 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13, 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 2 , 1930, to April 13, , 1930

that I last saw him alive on April 12, , 1930

and that death occurred, on the date stated above, at 2.30a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) not Known yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs and symptoms

(Signed) J. Edward Norris M. D.

4.13. 1930 (Address) 107 East west st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Charles Cem Pikesville

DATE OF BURIAL: April 15 th 1930

20 UNDERTAKER: A. Jones

ADDRESS: 111 S. Gilmor

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56133

REGISTERED NO. E 56133

1-PLACE OF DEATH

City of Baltimore: (No. 2041 E. Lombard St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter W. Freimann (Freimann)

(a) RESIDENCE NO. 2041 E. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Freimann

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1869

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
60.	4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Sewerage
(b) General nature of industry, business, or establishment in which employed (or employer): Department of Baltimore City.
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER William Freimann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christian Becker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Helen Freimann (Address) 2041 E. Lombard St.

15 Filed APR 14 1930 C. RAMSAY JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry found that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

CONTRIBUTORY (Secondary) Ex Lawson (duration) yrs. mos. — ds.

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) R. C. Blades, M. D.

(Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem.	April 14, 30
20 UNDERTAKER	ADDRESS
Wendell J. Wippel	200 S. Eden St

Fill in plainly with ink, so that it may be photographed. Be sure that every item is complete and important. See instructions on back of certificate.

Cor.—10-10-29—A Co—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56134

CERTIFICATE OF DEATH

90

E 56134

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1224 W Lombard St., 18-79 Ward)

2-FULL NAME Clara A. Bearaft

(a) RESIDENCE NO. 1224 W. Lombard St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year): Aug. 17 1867

7 AGE: Years 62 | Months 8 | Days 1 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None 037
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Pa
(State or country)

PARENTS

10 NAME OF FATHER: Jno H Kemler

11 BIRTHPLACE OF FATHER (city or town): Pa
(State or country)

12 MAIDEN NAME OF MOTHER: Sarah A Buddy

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Pa

14 Informant: Mr. Joseph Ernest
(Address): Reisterstown

15 Filed ..., 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'Donovan, M. D.

4/30 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apr 15 1930
20 UNDERTAKER	ADDRESS
Joseph L Cook	1103 N Eutaw St

APR 14 1930

Cor. 10-10-29—A Co—100 Bks.

Fill out all blanks in ink, or type-writer, and be sure that it may be read easily. Every question is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56135

CERTIFICATE OF DEATH

11-001

25-72

E 56135

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 DeSoto Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Henry Strauss

(a) RESIDENCE NO. 1019 DeSoto Road ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian E. Strauss

6 DATE OF BIRTH (month, day, and year) Oct. 22, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. and O. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER [illegible] Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Lillian Strauss

(Address) 1019 DeSoto Road

15 Filed APR 14 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 11. 1930. to April 12. 1930.

that I last saw him alive on April 12. 1930

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) aff 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (probably) Grippe

(duration) - yrs. - mos. 10 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) R. Gustav Lee M. D.

4/12. 1930 (Address) ~~1509~~ 1433 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Apr. 15 1930
UNDERTAKER Joseph D. Coon	ADDRESS 1003 West Baltimore St.

Spec.—1-12-23—M&T—500 Blks.

E 56136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56136

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1224 W. Lombard St. (ST.) 18-29 (WARD)

2-FULL NAME Eliza J. Buddy

(a) RESIDENCE NO. 1224 W. Lombard St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Forelady

(b) General nature of industry, business, or establishment in which employed (or employer) Vindex Co.,

(c) Name of employer Oppenheim Oberdorf Co.

9 BIRTHPLACE (city or town) Adams Co.
(State or country) Pa.

PARENTS

10 NAME OF FATHER Francis M. Buddy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Eliza Riddelmoser

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Basil D. Buddy
(Address) 1828 W. Saratoga St.

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April, 12 1930

17

I HEREBY CERTIFY, That I attended deceased from April 12th, 1930, to April 12th, 1930,

that I last saw h er alive on April 12th., 1930

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V. Coolahan M. D.

4/14 1930 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 4/15 1930

20 UNDERTAKER: [illegible] Cook — ADDRESS: 1003 N. Eutaw St.

Spec. 1-30—M. & T.—250 Bks.

E 56137 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56137

CERTIFICATE OF DEATH. 31

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals (M.B.) ST. 23-31 WARD

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wilson

(a) RESIDENCE NO. 35 W. Cross st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Flossie Robinson

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Hospital Records

(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20, 1930, to April 12, 1930, that I last saw him alive on April 12, 1930, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. Johnson Jr. M. D.

4-14-1930 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cape Charles Va.

DATE OF BURIAL 4/14 1930

ADDRESS 1399 W. Hendy St

20 UNDERTAKER Walter B. Spriggs

Spec.—1-30—M. & T.—250 Blks.

E 56138

E 56138 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1704 Sole St. ST. 14-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam H. Schreiner

(a) RESIDENCE NO. 1704 Sole St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Agnes Schreiner

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Schreiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. Amelia Mooney (Daughter) 4715 9th St. Wash. D. C.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10th, 1930, to April 11, 1930, that I last saw him alive on April 11, 1930, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Arterio Solerosis
Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry E Tittle, M. D.

4/14/30 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 4/15/30

20 UNDERTAKER Harry V. Weitzke — ADDRESS 410 Edmondson Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56139

CERTIFICATE OF DEATH

90 E 56139

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 7 N. Duncan ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Schmidt

(a) RESIDENCE NO. 7 N. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., If foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced (or) WIFE of Leopold Schmidt

6 DATE OF BIRTH (month, day, and year) July 28, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ralph G. Schmidt

(Address) 7 N. Duncan St

15 Filed 4-10-30 C. HAMPSON JONES, M. D. Registrar

R 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to April 11, 1930

that I last saw h alive on 3/11 1930

and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows: (a) Myocarditis

(duration) Yrs. mos. ds.

Arteriosclerosis Edema

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Bauer, M. D.

4/12, 1930 (Address) 7939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Apr. 15, 1930

20 UNDERTAKER John G. Connelly

ADDRESS Conway

Spec.—2-29-28—L. F. S.—500 Blks.

E 56140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56140

REGISTERED NO. 13-54

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2803 Parkwood Ave. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Wittgenstein

(a) RESIDENCE NO. 2803 Parkwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of David Wittgenstein

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ? Neuberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Ochs

(Address) 2803 Parkwood Ave

15 Filed APR 14 1930 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13th. 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 3 . 19 30 . to Apr 12 . 19 30 .

that I last saw h Exalive on Apr 12 . 19 30

and that death occurred, on the date stated above, at 6.45 A. m.

The CAUSE OF DEATH* was as follows:

Involved + Hypostatic Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Facial Erysipelas (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kaley, M. D.

, 19 (Address) 2027 W. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cheb Shalom Cem.

DATE OF BURIAL 4/15/ 1930

20 UNDERTAKER Harid Sandheim

ADDRESS 1020 W. Pratt Ave. Rear

Spec.—2-29-28—L. F. S.—500 Bks.

Fields

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56141

CERTIFICATE OF DEATH

E 56141

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bo. Balto Gen. Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonard Fields

(a) RESIDENCE NO. 300 E Broadway ST., N.Y. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11 yrs.	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Nathan Fields

11 BIRTHPLACE OF FATHER (city or town) Buffalo, N.Y.
(State or country)

12 MAIDEN NAME OF MOTHER Irene Strauss

13 BIRTHPLACE OF MOTHER (city or town) Buffalo N.Y.
(State or country)

14 Informant mother

(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 13, 1930, that I last saw h alive on April 13, 1930 and that death occurred, on the date stated above, at 10 38 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Appendicitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Peritonitis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? N.Y.C.

Did an operation precede death? Yes Date of Apr. 11, 1930

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) E. O. Pilcher, M. D.

, 19 (Address) 1-13 East 11

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	4/14/1930
20 UNDERTAKER	ADDRESS
David Sandheim	118-20 W. Mt. Royal Ave

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56142

CERTIFICATE OF DEATH.

E 56142

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital (Ward) 12-50

REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Payne

(a) RESIDENCE NO. 2312 Ashland Ave (Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Payne

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Co Va.

PARENTS

10 NAME OF FATHER Wm Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lucy Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Susie Payne Wife (Address) 2312 Ashland Ave

15 Filed 4 1930 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-11 . 1930 . to 4-12 . 1930

that I last saw him alive on 4-12 . 1930,

and that death occurred, on the date stated above, at 7 00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Laboratory

(Signed) M B Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gloucester Co. Va	April 14 1930
UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1725 Ashland Ave

TION is very important. See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2 E 56143 ✓ 118-002 E 56143

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

2—FULL NAME Matthew Howard

(a) RESIDENCE NO. Cedar Hill, Brooklyn Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Infant

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Hugh Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Campsie Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 By: C. HAMPSON JONES, M. Registrar

APR 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13-1930

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to April 13, 1930, that I last saw h[illegible] alive on April 13, 1930 and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis from thrombosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Intussusception (duration) 3 weeks yrs. mos. da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of April 9, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. W. Bickford, M. D.

4/13, 1930 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL Apr. 15 1930

20 UNDERTAKER Mrs R. G. Elliott

ADDRESS 1720 Eastlandon

Spec.—1-30—M. & T.—250 Bks.

E 56144 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56144

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Baltimore City Hospitals (3 B-W) REGISTERED NO. 29-31

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Appetito

(a) RESIDENCE NO. 16 W. Cross st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Appetito

6 DATE OF BIRTH (month, day, and year) Nov 17, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 37

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Vogel

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Strecker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar
APR 14 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1930, to April 12, 30,
that I last saw her alive on April 12, 30,
and that death occurred, on the date stated above, at 6.15 a. m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Jas G Hunes Jr M. D.
4-12 19 30 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	April 15, 1930
20 UNDERTAKER C. Howard Evans	ADDRESS 38 E Fayette

Spec.—1-30—M. & T.—250 Bks.

E 56145 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56145

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Baker St., 45-21 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Marshall

(a) RESIDENCE NO. 1624 Baker St. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	widow

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of Frank Marshall

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo Coomes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Clarence Marshall
(Address) 1624 Baker St

15 Filed 1-4 1930, 19 C. HAMPSON JONES, M. D. Registrar
By C. H. J.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930 to April 12, 1930
that I last saw her alive on April 11, 1930
and that death occurred, on the date stated above, at 11 15 m.

The CAUSE OF DEATH* was as follows:

Metal Stenosis

(duration) yrs. 3 mos 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) I. M. Stalter M. D.
4/14 1930 (Address) 1525 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hope cem Md.	4/14 1930
20 UNDERTAKER	ADDRESS
Daniel Easton	916 York

Spec.—1-12-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56146

CERTIFICATE OF DEATH.

10 1 3001 E 56146

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 516 E 28th ST. 9-46 WARD)

2-FULL NAME Mrs Mary Reed

(a) RESIDENCE NO. 516 E 28th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Emanuel Reed

6 DATE OF BIRTH (month, day, and year): Mr 20, 1840

7 AGE: Years 89 | Months 4 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): New Md Pennsylvania

PARENTS

10 NAME OF FATHER: John E Stalsmith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Adams County Pennsylvania

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Adams Co Pennsylvania

14 Informant: Mrs H J Reed (Address) 516 E 28th St.

15 Filed: 4 1930, 19 C. P. JAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-13 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-11 -, 1930, to 4-13, 1930, that I last saw her alive on 4-13, 1930, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Wm Edwards, M. D.

, 19 (Address) 7746 Alameda

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hamaker Iowa

UNDERTAKER: William Cook

DATE OF BURIAL: 4/15 1930

ADDRESS: 127 S Wood

Spec.—1-30—M. & T.—250 Blks

Dr Louise K 4706 Hartford Ave Hamilt 0220 0221

E 56147 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 56147

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1912 Oak Hill Ave ST. 9-18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert McKean

(a) RESIDENCE NO. 1912 Oak Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Emma B McKean

6 DATE OF BIRTH (month, day, and year) 12/25/1867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor 073

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer Penna R. R.

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Robert McKean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Emma B McKean

(Address) 1912 Oak Hill Ave

15 Filed ..... 19 ..... Registrar RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930 to April 12 1930.

that I last saw him alive on April 6, 1930.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary sclerosis with angina pectoris (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claude Smith, M. D.

April 14 1930 (Address) 4702 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 4/15/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Blks.

E 56148 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56148

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (NO. 15-68 ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christian Domer

(a) RESIDENCE NO. 1807 Dukeland Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-29-81

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? 040

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Conroy Domer

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Germany

12 MAIDEN NAME OF MOTHER Bobbs ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? U.S.A.

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12-30

17 I HEREBY CERTIFY, That I attended deceased from 4-3, 1932, to 4-12, 1930,

that I last saw him alive on 4-12, 1930,

and that death occurred, on the date stated above, at 1.25 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Autopsy

(Signed) Marvin M. McSteen, M. D.

4-13, 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 4/15/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56749 E 56749

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 N. Curley ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August George Kurs

(a) RESIDENCE NO. 132 N. Curley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) Wife of~~ Ella Kurs

6 DATE OF BIRTH (month, day, and year) Nov 5th 1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Kurs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Claude C. Kurs

(Address) 132 N. Curley St

Filed 4 1930 19 ARH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 1— 1930 to April 12 1930

that I last saw h[illegible] alive on April 12 1930

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Parenchymatous Nephritis

(duration) yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? At Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

7/8. 1930 (Address) 2616 Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL 4/15/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

Dr Zollers

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56150

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 19-27 Ward)

2-FULL NAME Edward G. Baker

(a) RESIDENCE NO. 1502 W Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lilly Baker

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
about 59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Unknown
(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Mrs Wm Jones
(Address) 4616 Frankfort Ave

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Gilbert, M. D.

4/14, 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	4/16/30
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56151

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST., 7-11 WARD) 101

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorraine Gaver

(a) RESIDENCE NO. 3003 McCleery ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	9 10	25 5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 021

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Butts

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Frederick Md

14 Informant Husb Nearest
(Address)

15 Filed 4 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13-30

17 I HEREBY CERTIFY, That I attended deceased from 4-9, 1930, to 4-13, 1930,
that I last saw him alive on 4-13, 1930,
and that death occurred, on the date stated above, at 9 55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyho, M. D.

4/13, 1930 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	4/16/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—1-30—M. & T.—250 Bks.

E 56152 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56152

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 15-62 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Virginia Fugette

(a) RESIDENCE NO. 3823 Barrington Rd St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, (Widowed,) or Divorced, (write the word)
F	W	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of or) WIFE of George

6 DATE OF BIRTH (month, day, and year) about 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Hardaster

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Dr. M. LeBauer Charles A. Pindell Millersville Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1930

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to April 13, 1930, that I last saw h[illegible] alive on April 12, 1930, and that death occurred, at the date stated above, at 8 AM m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/5/30

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Conn M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL 4/16/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

Dr Pillsbury 415 Cedarcroft Rd Tus 0269

E 56153 HEALTH DEPARTMENT—CITY OF BALTIMORE

37-09 E 56153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 441 E. 27th St. 12-50 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mabel D. Hess

(a) RESIDENCE NO. 441 E 27th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 3/12/1911

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
19	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady

(b) General nature of industry, business, or establishment in which employed (or employer) Dept Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph E. Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Edith M Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Joseph E. Hess

(Address) 441 E 27th St Balto Md

Filed APR 4 1930 C. HAMPSON CURRAN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 9, 1930, to April 13, 1930, that I last saw her alive on April 12, 1930, and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) 1 yrs. 1 mos 4 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Tests

(Signed) Wm D Pillsbury M. D.

4/14 1930 (Address) 415 Cedarcroft Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	4/16/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Spec.—8-16-29—L. F. S.—100 Blks.

E 56154 30 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 56154.

CERTIFICATE OF DEATH X 129

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

2—FULL NAME John W. Bassler

(a) RESIDENCE NO. Sunbury Pa ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret

6 DATE OF BIRTH (month, day, and year) Sept 10 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Chas W.

11 BIRTHPLACE OF FATHER (city or town) Pa (State or country)

12 MAIDEN NAME OF MOTHER Louisa N. Glace

13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 APR 4 1930, 19 RRM Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14-30

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to April 14, 1930, that I last saw h alive on April 14, 1930 and that death occurred, on the date stated above, at 6 40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) R Hooper Smith, M. D.

April 4 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sunbury Pa

DATE OF BURIAL Apr 15 1930

20 UNDERTAKER John B Mitchell

ADDRESS 1905 Eutaw Place

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56155 — 129 — E 56155

1-PLACE OF DEATH

REGISTERED NO.

City of Baltimore: (No. 516 Hanover St. St., 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Headen.

(a) RESIDENCE NO. 516 Hanover St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 9 mos. --ds. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July, ~~1851~~ 1861
Change made 4/17/30 E.M.K.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	68 ~~78~~	9	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Headen.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine Murn.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Mary E. Berger.
(Address) 1004 Hillien St.

15 Filed 1930 Registrar

R 1 5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heartland Kidneys.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted If not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What (test confirmed diagnosis? Inquiry
(Signed) Otto Leinhardt M. D.
4/14. 1930 (Address) 610 S. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudenhill Cemetery	4/15 1930
20 UNDERTAKER Fred A. Wannetson	ADDRESS 703 Hanover st

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56156

CERTIFICATE OF DEATH.

90 ✓ E 56156

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5504 Reisterstown Rd. ST.) (WARD) 28-63

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Melvina Little

(a) RESIDENCE NO. 5504 Reisterstown Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Little.

6 DATE OF BIRTH (month, day, and year) Jan. 26, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Elisha Scarf.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Harriett Frigwold

13 BIRTHPLACE OF MOTHER (city or town) Harford Co Md.
(State or country)

14 Informant Mr. David Little
(Address) 5504 Reisterstown Rd.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12 1930

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1930 & Seen to Time of death that I last saw he alive on 1. P.M., 19, and that death occurred, on the date stated above, at 7.20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis & Rheumatic patient & Lungs filled with blood

(duration) yrs. mos. ds.

CONTRIBUTORY, (Secondary)

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis Objective & Subjective Symptoms

(Signed) G. H. Buckley, M. D.

, 19 (Address) 3337 Belair Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Apl. 15 1930
20 UNDERTAKER Wm J Tickner Sons	ADDRESS North Pa

Cor.—10-10-29—A Co.—100 Bks.

E 56157

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56157

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 1102 Mt Lee Ave. St. 11-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elmer Max Kauffman

(a) RESIDENCE NO. 1028 Cathedral St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married.

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Regina Hobein Kauffman

6 DATE OF BIRTH (month, day, and year) May 31-1879

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	50	11	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Special Officer
(b) General nature of industry, business, or establishment in which employed (or employer) Fire Dept.
(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Marion Kauffman

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Meads

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hosp Record.
(Address)

15 Filed DEC 1 1930 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Scalp fell over Trouchain, Severe Contusion of Abdomen and Chest. — Pulmonary Embolism (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction 4 days

18 Where did disease originate if not at place of death? Fell at Island Park

Did an operation precede death? No Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Regular

(Signed) F B Linch M. D.

19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Dec 15 1930
20 UNDERTAKER Wm J Jackson Son	ADDRESS Balto

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56158

1-PLACE OF DEATH

City of Baltimore: (No. 4204 Eastern Ave St., No-37 Ward)

2-FULL NAME Unknown-White man.

(a) RESIDENCE NO. _____ St., _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

E 56158

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): _____

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant _____
(Address) _____

15 Filed _____ 19__ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Apoplexy.

_____ (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

_____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Eugene Zitter, M. D.

4/13. 1930. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY	19
20 UNDERTAKER: Commissioner Hospital	ADDRESS APR 14 1930

Property classified. Exact statement of occupation is very important. See instructions on back of certificate.

APR 15 1930 C. HAMILTON JONES, M. D.

Dep. Wm. R. Hou...

Spec.—1-30—M. & T.—250 Bks.

E 56159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/ E 56159

1-PLACE OF DEATH Baltimore City Hospitals (T.B.) ST., 36 WARD) 3 T

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Harry M. McKenzie

(a) RESIDENCE NO. Maryland Training School ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913 Aug 24

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown Neil McKenzie

11 BIRTHPLACE OF FATHER (city or town) England
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown Margaret

13 BIRTHPLACE OF MOTHER (city or town) N. Y.
(State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1929, to April 11, 1930, that I last saw him alive on April 11, 1930, and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Jno Ghrmed Jones M.D.

4-11-30 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL April 15 1930

20 UNDERTAKER Lilly + Zeiler Inc.

ADDRESS 408 S. Wolfe St

Spec. 1-30 M. & T.—250 Blks.

E 56160 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56160

92

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 S. Castle ST., 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Canavan

(a) RESIDENCE NO. 404 S. Castle ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick E Canavan

6 DATE OF BIRTH (month, day, and year) June 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Nora Canavan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick Canavan

(Address) 404 S. Castle St.

15 Filed APR 5 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13/30

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1930, to April 13, 1930, that I last saw h[illegible] alive on April 12, 1930, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolus

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Cholecystitis

(duration) yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms & Finding

(Signed) Leon Heller M. D.

4/14, 1930 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL April 16 1930

20 UNDERTAKER Lilly & Zeller Inc

ADDRESS 403 S. Wolfe St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

94001

E 56161

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 711. N. Calhoun ST. 16-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta Elickson

(a) RESIDENCE NO. 711. N. Calhoun ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Marr

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel Elickson

6 DATE OF BIRTH (month, day, and year): Unknown 1860

7 AGE: Years 70; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 01

(c) Name of employer: Snow Hill

9 BIRTHPLACE (city or town) (State or country): Snow Hill

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mary Booker

(Address): 711 N Calhoun St

15 Filed 5-1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 12-30

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1930, to April 12, 1930, that I last saw h alive on April 12, 1930, and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Paralysis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical

(Signed) Chas H. Tompkins M. D.

4-14, 1930 (Address) 1512 N. Lafayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: Apr 15, 1930

20 UNDERTAKER: Chas H Grace & Son

ADDRESS: 1400 Madison

Spec.—1-30—M. & T.—250 Blks

E 56162

Harrison & Edgerton Roads

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56162

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3902 Dorchester Rd. ST. 5-63 WARD

2-FULL NAME Charles Frederick Berger

(a) RESIDENCE NO. 3902 Dorchester Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Sue Berger

6 DATE OF BIRTH (month, day, and year) Dec 5- 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager 496

(b) General nature of industry, business, or establishment in which employed (or employer) Ad Press Print Co

(c) Name of employer Ad Press Print Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Martin Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Cora Sue Berger

(Address) 3902 Rockdale Rd

15 Filed ..... 19.... Registrar

5 13 30 HARRY S. JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1930, to April 13, 1930, that I last saw h alive on April 13, 1930, and that death occurred, on the date stated above, at 1045 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm G Dunn, M. D.

4/14, 1930 (Address) 860 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Ridge — DATE OF BURIAL April 15 1930

20 UNDERTAKER Wm Cook — ADDRESS 121 St Paul.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56163 ✓ 001 74 E 56163

E 56163

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3672 Falls Road ST., 10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia A. Lutz

(a) RESIDENCE NO. 1310 Morling Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John F. Lutz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara A. Brook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary E. Shuck

(Address) 3672 Falls Road

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12-1930

17 I HEREBY CERTIFY, That I attended deceased from Mar. 29. 1930. to apr 12. 1930

that I last saw her alive on apr 12 1930

and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

apoplexia

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY Arteria Sclerosis.
(Secondary)
Previous attack (duration) 7 yrs. ... mos. ... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/14. 1930 (Address) 2020 N. Charles.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Baltimore Co.

DATE OF BURIAL April 16 1930.

20 UNDERTAKER Horace F. Burgee

ADDRESS 3631 Falls Road

Spec.—8-16-29—L. F. S.—100 Blks.

E 56164

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56164

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-2-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lamar Dickerson

(a) RESIDENCE NO. 1014 N. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8yr. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Lamar M. Dickerson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Tennessee

12 MAIDEN NAME OF MOTHER Perrie Yassama

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Records

(Address)

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14/30

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1930, to April 14, 1930, that I last saw h.e alive on April 14, 1930 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Scarlet fever.

(duration) ....yrs. 10 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contrarted if not at place of death? 1014 N Carey St.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Skin rash

(Signed) J W Bickford, M. D.

4/14. 1930 (Address) J H H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 4/15 1930

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

Cor.—10-10-29—A Co.—100 Bks.

E 56165

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 56165

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Enroute to Hopkins Hospital St. 14-20 Ward)

2-FULL NAME Mary T. Scott

(a) RESIDENCE NO. 548 Wilson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
female	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5/1929

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or min.
	1	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Herman Scott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Bertha Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Irene Smith
(Address) 548 Wilson St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. about 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History by Dr. White

(Signed) [signature] M. D.

4/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	4/15 1930
20 UNDERTAKER Thomas E. Nelson	ADDRESS 503 Pulaski

Important. See instructions on back of certificate.

APR 15 1930 C. BAMFORD CONDIT

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56166

CERTIFICATE OF DEATH.

90 E 56166

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3508 Pool St. 13-57 Ward

2-FULL NAME Elizabeth Robinson

(a) RESIDENCE NO. 3508 Pool St. 13 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: William Robinson

6 DATE OF BIRTH (month, day, and year): 13 Oct - 1844

7 AGE: Years 85 Months 6 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co.

PARENTS

10 NAME OF FATHER: John Scattins

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. S. A

12 MAIDEN NAME OF MOTHER: Mary Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Mr. Ella Stolley 3512 Pool St

15 Filed 19

Per Registrar

C. HAMPSON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) and from other sources I find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Interlobular Diffuse Heart Disease

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

Signed: C. Hampson Jones (Coroner) M. D.

4/14 1930 (Address) 7832 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death..... yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mary Hampstead Park Date of Burial 4/15 1930

20 UNDERTAKER: A. S. Marshall ADDRESS 3539 Falls Rd

Spec.—1-30—M. & T.—250 Blks.

E 56167

E 56167 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37-002

1-PLACE OF DEATH Baltimore City Hospitals (T.B.)

CITY OF BALTIMORE: (NO. 23-31 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clinton Smith (Clinton Thomas)

(a) RESIDENCE NO. 1005 Plum Alley ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Asbury Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 4-19-1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1930, to April 11, 1930,

that I last saw him alive on April 11, 1930,

and that death occurred, on the date stated above, at 12.20 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous polyserositis

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas G Emmart Jr M. D.

4-11 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL 4/13 1930

20 UNDERTAKER Walter B. Springs

ADDRESS 539 W. Lombard St

Cor.—10-10-29—A Co.—100 Bks.

E 56168

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56168

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Provisional and Metropolitan Hospital

City of Baltimore: (No. 1430 E. Fayette St. Ward)

2-FULL NAME Jennette Warren

(a) RESIDENCE NO. 1430 E. Fayette St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	C.	single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Centenary 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hemster
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) Vt
(State or country)

PARENTS

10 NAME OF FATHER George Warren

11 BIRTHPLACE OF FATHER (city or town) Vt.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Brunn

13 BIRTHPLACE OF MOTHER (city or town) Vt.
(State or country)

14 Informant Ella Landry R.
(Address) 1506 Eastern Ave

15 Filed ..... 19.. C. HAMPSON ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquest find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage-stab wound in heart & lung (Homicide)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) H. K. Oliver, M. D.

4/15/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Apr. 15 1930
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1715 Madison Ave

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56169

HEALTH DEPARTMENT—CITY OF BALTIMORE

92 E 56169

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 457 N 24th ST. 12-51 WARD)

2-FULL NAME Thompson Wesley Ernest

(a) RESIDENCE NO. 451 N 24th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada P. Ernest

6 DATE OF BIRTH (month, day, and year) Dec 1. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	58	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Balto City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Wesley H Ernest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Malinda Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Ada P. Ernest (Address) 451 N 24th

15 Filed APR 15 1930 C. BAKER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13-1930

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to April 13, 1930, that I last saw him alive on April 13, 1930, and that death occurred, on the date stated above, at 9 35 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 4-13-30

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A J Daner, M. D.

4-14-1930 (Address) 600 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL Apl 16 1930

20 UNDERTAKER John Leerich

ADDRESS 2008 Orleans

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56170

CERTIFICATE OF DEATH

101-001

E 56170

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 709 N. Mount St., 16-27 Ward)

2-FULL NAME Carrie Brown

(a) RESIDENCE NO. 709 N. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col.

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: no.

6 DATE OF BIRTH (month, day, and year): Nov 1927

7 AGE — Years: 2 | Months: 5 | Days: | IF LESS than 1 day... hrs. or... min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country): Md

PARENTS

10 NAME OF FATHER: Jas Brown

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Martha Wellington

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Martha Brown
(Address): 709 N Mount

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

APR 15 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Recognized

(Signed) H. Leech, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Apr. 15 1930

20 UNDERTAKER: Virginia A. Booker — ADDRESS 1763 N. Carey St.

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56171

CERTIFICATE OF DEATH.

E 56171

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 22-21 WARD)

2-FULL NAME Baby Girl Cecelia Elizabeth Mordy

(a) RESIDENCE NO. 811 Sharp ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elsie Mordy

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
Unknown about	40	40		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Mary Land

PARENTS

10 NAME OF FATHER Richard Butler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Louisa ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Hospital Record
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12-30

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1930, to 4-12, 1930, that I last saw h.e alive on 4-12-, 1930, and that death occurred, on the date stated above, at 11:57 m.

The CAUSE OF DEATH* was as follows:
Carcinoma Left breast

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Cumpston M. D.

4-13, 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL Apr 15 1930

20 UNDERTAKER A. L. Bloom's Son

ADDRESS Forest Park

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 56172 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56172

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: No 825 Pierce St. 16-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Iru Bell

(a) RESIDENCE. No 825 Pierce st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Bell

6 DATE OF BIRTH (month, day, and year) Feb 9. 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33 yrs	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Schlenes

(c) Name of employer Transfer Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Noah Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Charlotte Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Noah Bell
(Address) 1334 Gorsuch st.

15 Filed . 19 Registrar

APR 15 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12 1930

17 I HEREBY CERTIFY, That I attended deceased from about Oct 1928 19 . to April 12 . 1930 that I last saw h[illegible] alive on April 12. 1930 and that death occurred, on the date stated above, at 12 N m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H H Gorsuch . M. D.

4-15-1930 (Address) 1107 W. Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U S National Cem	April 16 1930
20 UNDERTAKER	ADDRESS
H. E. Bucknell Son	1111 W. Fayette

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56173

CERTIFICATE OF DEATH

11 V E 56173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 306 S Bruce St. 14-28 Ward)

2-FULL NAME George F. Hess

(a) RESIDENCE NO. 306 S Bruce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 22 1924

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	6	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nothing
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward R Hess

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Augusta A Lambert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Edward R Hess
(Address) 306 S Bruce St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Influenza & Complications

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas O'D Brooks M. D.

Apr 15, 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr 14 1930
20 UNDERTAKER	ADDRESS
Jarrah Lyssa	1640 N Monroe

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 56174

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 226 N. Fremont St. 18-12 WARD)

REGISTERED NO. 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Brittingham

(a) RESIDENCE NO. 226 N. Fremont ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 77

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Preacher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lottie Rice

(Address) 226 N. Fremont St.

Filed 4-15, 1930 C. HAMPSON GORTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 6, 1930, to Apr 12, 1930, that I last saw him alive on Apr. 12, 1930, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. W. Pigott, M. D.

4/15, 1930 (Address) 1536 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 4-15 1930

20 UNDERTAKER: John W. Forsdun

ADDRESS 1027 Round Hill

Cor.—10-10-29—A Co.—100 Bks.

E 56175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 56175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3220 Montebello Road St., 12-49 Ward)

2-FULL NAME Pietro Pipitone

(a) RESIDENCE NO. Highfield & Norwood Rds., Ward

(Usual place of abode) 42 (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mns. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Pipitone

6 DATE OF BIRTH (month, day, and year) May 17/1872

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	57	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Building Contractor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Self

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Frank Pipitone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Vita Alagna

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Jerome Pipitone
(Address) Montebello Road

Filed ... 1930 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probbaly Cardiac Insufficiency

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ... M. D.

4/14/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 16 1930
20 UNDERTAKER Frank V. Pipitone	ADDRESS 2918 E. Balto

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56176

CERTIFICATE OF DEATH

46 ✓ E 56176

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 Dolphin ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha ayers

(a) RESIDENCE NO. 535 Dolphin ST., 17 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)

6a If married, ~~widowed, or divorced~~ (a) WIFE of George ayers

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Buckham Co Va

PARENTS

10 NAME OF FATHER: Moses Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Buckham Co Va

12 MAIDEN NAME OF MOTHER: Mary Gaines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Buckham Co Va

14 Informant: Sylvester ayers

(Address): 535 Dolphin st

15 Filed APR 15 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 17, 1930, to April 14, 1930, that I last saw her alive on April 11, 1930, and that death occurred, on the date stated above, at 10 P.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? yes Date of About 1 yr ago

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Exam.

(Signed) Thos. D. Woolridge, M. D.

4/15 1930 (Address) 703 W Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Buckham Co Va

DATE OF BURIAL: April 15 1930

20 UNDERTAKER: John H Owens

ADDRESS: 535 Dolphin st

Cor.—10-10-29—A Co.—100 Bks.

E 56177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 56172

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 435 S Chester St., 1-3 Ward)

2-FULL NAME Martin Nitkad

(a) RESIDENCE NO. 435 S Chester St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth 2-5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a ~~If married, widowed, Divorced~~ HUSBAND of ~~or WIFE of~~ Fanca. Nitkay

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs or ..min.
	64	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Vera Krasnowanza
(Address) 435 Chester

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

DEC 15 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, Autopsy or Inquiry.)
thereon and from the evidence obtained by said Inquest, aforesaid find that said deceased came to his death
(Autopsy or Inquiry)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Chr Myocarditis
Lobar Pneumonia
(Duration) 1 yrs. 7 mos. 7 ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
12/31/30
(Signed) C. Hampson Jones, M. D.
19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	12/16 1930
20 UNDERTAKER	ADDRESS
Wm Gallagher	618 Eastern

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

23568178 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH X 49 E 56178

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-50 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vera Pollard

(a) RESIDENCE NO. 2308 Guilford av ST., WARD 9a
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown 1880

7 AGE: Years: about 50; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown 87

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va or W Va

PARENTS

10 NAME OF FATHER: Chas Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Betty Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr-14-1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 11, 1930, to Apr 14, 1930, that I last saw her alive on Apr 14, 1930 and that death occurred, on the date stated above, at 6 10 A m.

The CAUSE OF DEATH* was as follows:

1 Brain Tumor months Supposed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4 9 30

Was there an autopsy? Yes

What test confirmed diagnosis? X ray

(Signed) C. H. Jones, M. D.

, 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va

DATE OF BURIAL: Apr 15 1930

20 UNDERTAKER: Mrs. R. G. Elliott

ADDRESS 715 Westhampton

Spec.—1-10-21—M&T—1500 Blks.

46 V

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56179

E 56179

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 N. Carey st. ST. 18-26 WARD)

2-FULL NAME Jennie Thomas.

(a) RESIDENCE No. 303 N Carey St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wm. Thomas

6 DATE OF BIRTH (month, day, and year) Unknown 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rosetta Edmonds. (Address) 303 N. Carey st.

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1930

17 I HEREBY CERTIFY, That I attended deceased from April 17 . 1930 . to April 17 . 1930 .

that I last saw her alive on April 17 . 1930 .

and that death occurred, on the date stated above, at 8 PM m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

10 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Occl. Fibrosis Uterus

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hamilton Jones, M. D.

, 1930 (Address) 707 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 15 1930
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1125 Lombard

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. E. S.—500 Blks.

E 56180 Navy Miller E 56180

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725) Edmonth St ST., 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Celia Miller

(a) RESIDENCE NO. 1725 Edmonth St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	C.	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Miller

6 DATE OF BIRTH (month, day, and year) Apr 6 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41		12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Mary Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Isabella Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Celia Miller

(Address) 1725 Edmonth St

15 Filed APR 15 1930 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13 30

17 I HEREBY CERTIFY, That I attended deceased from Feb 5 1930 to April 13 1930

that I last saw him alive on April 12 1930

and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach with Secondaries and Internal Hemorrhage and Lasting Complications of the Heart (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Heart Failure (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) E. Hall, M. D.

19 (Address) 1826 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prince Edward Co Va.

20 UNDERTAKER H. W. K. Elliott

DATE OF BURIAL Apr 15 1930

ADDRESS 1725 Edmonth St

Spec.—2-29-28—L. F. S.—500 Blks.

E 56181

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56181

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Maier

(a) RESIDENCE NO. Creston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Maier

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Hoffmaier

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Barbara Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor

(Address) Creston & Valley Sts

15 Filed APR 15 1930 HAMILTON JONES, M. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14/30

17 I HEREBY CERTIFY, That I attended deceased from 4/5, 1930 to 4/14, 1930 that I last saw h alive on 4/13, 1930 and that death occurred, on the date stated above, at about 3 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) 8 yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Benedict M. D.

4/14 1930 (Address) 1716 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Apr. 16 1930
20 UNDERTAKER Henry Hauck Sons, Inc.	ADDRESS 130 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 56182

E 56182

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2012 Bolton ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miles E Wright

(a) RESIDENCE NO. 2012 Bolton ST., WARD 5

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer Ret'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John H Marshall
(Address) Safe Deposit Trust

15 Filed 4/15 1930 C. HAMILTON JONES, M. D. Registrar

R 1 5 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13 1930

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to Apr 13, 1930, that I last saw him alive on Apr 13, 1930, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 26 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C V S Jones, M. D.

4/14, 1930 (Address) 720 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 15 1930

20 UNDERTAKER George L Smith

ADDRESS 1532 Hollins St

Spec.—1-10-21—M&T—1500 Blks.

56183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 56183

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 647 W. Fayette ST. 11-25 WARD)

2-FULL NAME Kate Cademore

(a) RESIDENCE NO. 647 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 58 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John Cademore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Louise Denmar

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Albert Cademore

(Address): 1405 Monument St

15 Filed , 19 Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1930

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to April 13, 1930, that I last saw h[illegible] alive on April 13, 1930, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glenman M. D.

April 15 1930 (Address) 2680 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: April 16 1930

20 UNDERTAKER: Harzfeld & Flynn — ADDRESS: 1477 Light St.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 56184 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56184

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balto Gen Hosp

CITY OF BALTIMORE: (No. Baltimore, Md 15-21 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Moses Friedman

(a) RESIDENCE NO. 1556 N Fulton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Sobel Friedman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glazier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Lem Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Mrs Moses Friedman 1556 N Fulton

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15 1930

17

I HEREBY CERTIFY, That I attended deceased from March 27 1930, to April 15 1930, that I last saw h[illegible] alive on April 15, 1930 and that death occurred, on the date stated above, at 4 30 a m

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Prostatic hypertrophy

Cardio-vascular disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy of Prostate Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? yes Date of 7-10-30

Was there an autopsy? no

What test confirmed diagnosis? Clinical diagnosis

4/15 1930 (Signed) S A Hess M. D.

(Address) Westport Medical Corp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 4/15 1930

20 UNDERTAKER Jack Lewis 1739 E Balto St — ADDRESS

SIGNATURE OF PERSON MAKING THIS CERTIFICATE MUST BE IN INK

T. SCOTT HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 56185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56185

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Whittier Ave ST. 13-54 WARD)

2-FULL NAME Samuel Seidman

(a) RESIDENCE NO. 2211 Whittier Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Solomon Seidman

6 DATE OF BIRTH (month, day, and year): 1856

7 AGE — Years: 74 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Hyman Romm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Elda —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Solomon Seidman
(Address): 2211 Whittier Ave

15 Filed MAY 5 1930 Per: C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/14/30

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2nd, 1929, to April 14, 1930, that I last saw her alive on April 14, 1930, and that death occurred, on the date stated above, at 3 00 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. J. Gunby, M. D.

4/14, 1930 (Address) 7320 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hessing Rem — DATE OF BURIAL: 4/16/30

UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balt St

Spec.—1-30—M. & T.—250 Bks.

E 56186

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3417 Mondawmin Ave 15-61 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Aubrey Silance

(a) RESIDENCE NO. 3417 Mondawmin Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Jane Silance

6 DATE OF BIRTH (month, day, and year) June 24, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Patrolman 61

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Police Dept.

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Wm. T. Silance

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Pickard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co. Md

14 Informant (Address) Mrs. E. Pickard Leatherbury 4606 Park Heights Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1930

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 13, 1930, that I last saw h[illegible] alive on April 13, 1930, and that death occurred, on the date stated above, at 1245 P. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gray —, M. D.

(Address) 6 W. Read Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Apl 16 1930
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Son	N. Pa. Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dennis E. Gaither

(a) RESIDENCE NO. Homewood apts Charles & 33rd Sts WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): ~~married~~ Widower

5a If married, widowed, or divorced, (or) WIFE of: Alice Maude Gaither

6 DATE OF BIRTH (month, day, and year): July 14 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Traveling salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Munkirk Ind

PARENTS

10 NAME OF FATHER: Dennis Gaither

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind

12 MAIDEN NAME OF MOTHER: Mahala Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind

14 Informant: Ernest Gaither

(Address) 4474 Underwood Rd

15 Filed Apr 15 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 14, 1930, (that I last saw him alive on Mon. April 14, 1930 and (that death occurred, on the date stated above, at 10 50 Pm.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 15 ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

Terminal (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Francis W Speck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Apr 16 1930
20 UNDERTAKER: Wm J Tuckerman Son	ADDRESS: N. Y. Pa

APR 15 1930

HARRISON JONES M D

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 V

E 56188

REGISTERED NO. E 56188

E 56188
1-PLACE OF DEATH

City of BALTIMORE: (No. 4128 Edmondson Av St. 16-66 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marguerite B. Wyandrelah

(a) RESIDENCE NO. 4128 Edmondson Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S. if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. W. Wyandrelah

6 DATE OF BIRTH (month, day, and year) March 18 - 1849

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	81		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 37

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(r) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Conrad Wells

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Blum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Louis L. Wells

(Address) 4128 Edmondson Ave.

15 Filed APR 15 1930 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14-1930 19

17 I HEREBY CERTIFY, That I attended deceased from April 2 1930, to April 14 1930,

that I last saw h[illegible] alive on April 14 1930,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) ... yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Senile Neptitis

(duration) 2 yrs. mos ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter E Trueheart M. D.

4/15 1930 (Address) 2002 N. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

Date of Burial April 16 1930

20 UNDERTAKER Wilbur H. Shivers

ADDRESS 4730 Edmondson Ave

very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 56189

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56189

CERTIFICATE OF DEATH

95-76 74

1-PLACE OF DEATH

City of Baltimore: (No. 8108 Remley St. Fairfield. St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Tolodziecki.

(a) RESIDENCE NO. 8108 Remley St. Fairfield St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. --- mos. --- dys. How long in U. S., If of foreign birth? 40 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of ~~or WIFE of~~ Magdaline Tolodziecki.

6 DATE OF BIRTH (month, day, and year) December 8, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
	64	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(r) Name of employer

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER Andrew Tolodziecki

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Frances ---

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Magdalina Tolodziecki. (wife)
(Address) 8108 Remley St. Fairfield.

15 Filed APR 15 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

4/15, 1930 (Address) 101 W. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A.C. Co.	April 16 1930
20 UNDERTAKER	ADDRESS
F. W. Ozgowski	900 Eastern Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56190 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56190

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (NO. 4-26 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Lane

(a) RESIDENCE NO. 723 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Chambers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Julia Grahm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed T 5 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11-30

17 I HEREBY CERTIFY, That I attended deceased from 7-17-29, 19..., to 4-11-30, 19...,

that I last saw her alive on 4-11-30, 19...,

and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Syphilis, tertiary

over 1 year

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

over 1

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & W.R.

(Signed) Warren H. McLane, M. D.

4-12, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 19...

ADDRESS 221 Schroeder St

UNDERTAKER Mrs. Peter R. Williams

Spec.—1-30—M. & T.—250 Bks.

E 56191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 56191

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 12-19 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Foster

(a) RESIDENCE NO. 310 E. Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gladys Louise

6 DATE OF BIRTH (month, day, and year) Dec. 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
25	26	4	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Red Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lilly May ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Records of Balto. City Hosp.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-30

17 I HEREBY CERTIFY, That I attended deceased from 4-8-30, 19..., to 4-15-30, 19...,

that I last saw him alive on 4-15-30, 19...,

and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Padget, M. D.

4-15, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg Va

DATE OF BURIAL 4/15, 1930

20 UNDERTAKER Chas. S. Evans & Son

ADDRESS 116 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56192 ## E 56192

E 56192

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2203 Mura St. ST. 8-17 WARD)

2-FULL NAME Minnie Roth.

(a) RESIDENCE NO. 2203 Mura St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of) Henry Roth

6 DATE OF BIRTH (month, day, and year) November 15th. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	72	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles F. Boucher

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Minna C, Husman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Roth

(Address) 2203 Mura St.

Filed APR 15 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 1929, to Apr 16, 1930.

that I last saw her alive on Apr 15, 1930.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Paralysis

(duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Cancer of Rectum

(duration) yrs. 6 mos. da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) ... M. D.

(Address) 1301 N Rad Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery.

DATE OF BURIAL April 16 1930

(UNDERTAKER) Edward R. Bruce & Son

ADDRESS 1101 N. Charles St.

'TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56193

100-001 E 56193

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 E 20th St. 12-50 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Tridone

(a) RESIDENCE NO. 407 E 20th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26th 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Albert Tridone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Antinella Polcari

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Albert Tridone
(Address) 407 E 20th St

15 Filed ... 19... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 17, 1930, that I last saw him alive on April 17, 1930 and that death occurred, on the date stated above, at 1.130 P. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia
(Primary)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis S. Ruby, M. D.

4/15, 1930 (Address) 42 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 16th 1930
20 UNDERTAKER	ADDRESS
George Schilling & Sons	112 E. Monument St.

Spec.—1-30—M. & T.—250 Bks.

E 56194

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-901 E 56194

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 6-10 WARD)

2-FULL NAME Baby Boy Koenig

(a) RESIDENCE NO. 2900 E Baltimore St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work /

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer /

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER David Koenig

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Mary Koenig

13 BIRTHPLACE OF MOTHER (city or town) Balt Md.
(State or country)

14 Informant
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11-30

17 I HEREBY CERTIFY, That I attended deceased from April 9 , 1930 , to April 11 , 1930 ,

that I last saw him alive on April 11, 6 A.M. 1930 ,

and that death occurred, on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Necropsy

(Signed) H Helen Kaelber M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

APR 14 1930

Spec.—8-16-29—L. F. S.—100 Bks.

E 56195

235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓

E 56195

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albina Tuma

(a) RESIDENCE NO. 1526 S. Thame ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 51 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records JOHNS HOPKINS HOSPITAL

(Address)

15 Filed APR 15 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10 '30

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1930, to April 10, 1930, that I last saw her alive on April 10, 1930 and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia 27 days

Pericarditis, hypostatic edema

Pneumococcus, septicaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Culture X-ray etc.

(Signed) Ludwig Kaerny, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS

APR 14 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56196

CERTIFICATE OF DEATH

90 E 56196

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1716 N Mount St. 15-21 (Ward)

2-FULL NAME Nellie Ward

(a) RESIDENCE No. 1716 N. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmd	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Ward.

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
48	47			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) Charlestown
(State or country) Md.

PARENTS

10 NAME OF FATHER Chas Smith

11 BIRTHPLACE OF FATHER (city or town) East Lap
(State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) East Lap
(State or country) Md

14 Informant Wm Ward
(Address) 1716 N Mount St.

15 Filed ..... 19 .....
Registrar

5 1930 15545

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 2nd 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Abel Hoffman, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
C. Hilbert Jones
Commissioner Health
APR 15 1930

Of DEATH in plain terms. Do not use abbreviations or terms of doubtful meaning. Be particular and answer each question fully. Underline the cause which is the principal one. Sign and return certificate immediately. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

E 56197

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56197

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals (T. B. ...)

CITY OF BALTIMORE: (No. ... ST. 17-26 (WARD)

REGISTERED NO. ...
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Holmes

(a) RESIDENCE NO. 731 Pierce st. ST., ... WARD ...
(Usual place of abode)
(Length of residence in city or town where death occurred Unknown yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.)
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
25	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Isaac Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records
(Address) UNIVERSITY OF MARYLAND

15 Filed 4-16-30 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1930, to April 7, 1930, that I last saw him alive on April 7, 1930, and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jas Gilmore Jr. M. D.

4-7, 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ...

DATE OF BURIAL ... 19 ...

20 UNDERTAKER Commissioner Health

ADDRESS APR 7 1930

Spec. 2-29-28—L. F. S.—500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56198

CERTIFICATE OF DEATH

90 E 56198

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 Annah ST. 16-68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J. Honigan

(a) RESIDENCE NO. 2400 Annah ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6 If married, widowed, or divorced: HUSBAND of (or) WIFE of Estelle Riel Honigan

6 DATE OF BIRTH (month, day, and year) Nov 29th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager 086

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Department

(c) Name of employer Gimbel Bros N.Y.

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Patrick Honigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Estelle Riel Honigan

(Address) 2400 Annah ave

15 Filed 5 1930 Per — 19 — Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 19. 1929. to Apr 13 . 1930 that I last saw he alive on Apr 13 . 1930 and that death occurred, on the date stated above, at 9308. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest W. Baker, M. D.

4/14 . 1930 (Address) 300 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Park → DATE OF BURIAL 4/16/1930

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson

Spec.—1-30—M. & T.—250 Bks.

E 56199

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56199

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4109 Montana ST. 27-42 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin D. Fletcher

(a) RESIDENCE NO. 4109 Montana ave ST. WARD

(Usual place of abode) Unknown

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa E. Fletcher

6 DATE OF BIRTH (month, day, and year) Dec. 17th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Allentown Pa.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Theresa E. Fletcher (Address) 4109 Montana ave.

15 Filed 4-15-1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1930

17

I HEREBY CERTIFY, That I attended deceased from 2/15, 19 28, to 4/14/5, 19 30

that I last saw him alive on 4/15, 19 30

and that death occurred, on the date stated above, at 240 a. m.

The CAUSE OF DEATH was as follows*:

Acute Broncho Pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Valvular heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakwood Cemetery

DATE OF BURIAL April 17, 30

20 UNDERTAKER Frederick Sasse & Sons

ADDRESS Baltimore

Spec.—1-10-21—MAT—1500 Blks.

E 56200

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 56200

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3200 Hamilton ave ~~St.~~ WARD) 27-43

2-FULL NAME Mrs. Meta Famme

(a) RESIDENCE NO. 3202 Hamilton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Vehemer yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augustus Famme

6 DATE OF BIRTH (month, day, and year) Sept. 13 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	87	6.	4 weeks	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 027

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Bremen (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Bremen (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Bremen (State or country) Germany

14 Informant Mrs. Hettie Faide (Address) 3202 Hamilton ave

15 Filed APR 11 1930 . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1930

17 I HEREBY CERTIFY, That I attended deceased from February 1st . 1930 . to April 7th . 1930 .

that I last saw h[illegible] alive on April 7th . 1930 .

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease.
Mitral Stenosis

(duration) 1 yrs — mos — ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) 5 yrs — mos — ds.

18 Where was disease contracted if not at place of death? at her residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) George C. E. Vogler . M. D.

. 19 (Address) 3000 Hamilton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery DATE OF BURIAL April 16 1930

20 UNDERTAKER Frederick Sievers ADDRESS Fullerton

TION is very important See instructions on back of certificates.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56201

CERTIFICATE OF DEATH

90

E 56201

1—PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 555 E. 38th ST., 9-47 WARD)

2—FULL NAME William H. Doyle

(a) RESIDENCE NO. 555 E. 38th ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 0 mos. 15 How long in U. S., If foreign birth? — yrs. — mos. — da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Mar. 24, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	43	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer Mass. M. L. I. Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Doyle

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine A. Flynn

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Ireland

14 Informant Mrs. Bessie Reid
(Address) 555 E. 38th Street

15 Filed 1 5 1930 19 C. HAMPSON JONES, M. D. Registrar
By _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 30. 1929. to Apr 14. 1930.
that I last saw h alive on April 14. 1930
and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis - decompensation and dilatation heart

(duration) yrs 10 mos. da.

CONTRIBUTORY (Secondary) _____
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Signal

(Signed) F. J. Kirby, M. D.

4 [illegible], 1930 (Address) 110 E Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 4/16 19 30

20 UNDERTAKER: Henry W. Myers & Son

ADDRESS: 805 W Calvert

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56202

CERTIFICATE OF DEATH

197 E 56202

1-PLACE OF DEATH

City of Baltimore: (No. President Park St., 15-21 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edw. F. Savage, Jr.

(a) RESIDENCE NO. 1534 Leslie St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula Savage

6 DATE OF BIRTH (month, day and year) Oct 28 - 1903

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	26	5	14/15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Truck Driver
(b) General nature of industry, business, or establishment in which employed (or employer) 023
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Edw F Savage
11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)
12 MAIDEN NAME OF MOTHER Emma Wilson
13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Edward Savage
(Address) 1652 Leslie

15 Filed 4/15 1930 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 12 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide.
Hemorrage due to pistol wound of lung & Bowel. (duration) yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mount & Mosher

Did an operation precede death? No Date of

Was there an autopsy? Autopsy

What test confirmed diagnosis? Autopsy findings

(Signed) H. Schmidt M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M.D. Cadaver	April 16 1930
20 UNDERTAKER	ADDRESS
Chas. H. Sloan & Son	1408 Mosher

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56203

CERTIFICATE OF DEATH

101-001 ✓

E 56203

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 831½ W. Fairmount Ave Ward)

2-FULL NAME Martha T Fleet

(a) RESIDENCE NO. 831½W. Fairmount Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William T Fleet

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Rosa Gourie
(Address) 1512 McCulloh St

15 Filed 19 Registrar

5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and, from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fellers, M. D.

4/15, 1930, (Address) 2 S Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	4/16 1930
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1307 Preastman.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56204

CERTIFICATE OF DEATH

90 E 56204

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 334 E Lindlewood St. 21st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary D. Singer

(a) RESIDENCE NO. 334 E Lindlewood ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Leo. G Singer

6 DATE OF BIRTH (month, day, and year): Sept 25 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Richard L Boyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Obst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Ford B. Singer

(Address) 334 E Lindlewood

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13/30

17 I HEREBY CERTIFY, That I attended deceased from March 1930, to April 13 1930

that I last saw her alive on April 13 1930

and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Intussusception (Mechanical Ileus)

Enterio Colitis

Cerebral Hemorrhage

(duration) Last Hour dr

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norbert C Nitsch M. D.

(Address) 2157 Williams Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 4/16/30

20 UNDERTAKER: St Peters Cemetery Funeral Service

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56205

CERTIFICATE OF DEATH

E 56205

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at St. Joseph Hospital

City of Baltimore: (No.) St. 10-14 (Ward) 90

2-FULL NAME William P. Dunphy

(a) RESIDENCE NO. 1206 E. Chase St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
about 53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick J. Dunphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Martin Dunphy
(Address) 1206 E. Chase St

15 Filed ..... 19 ..... Registrar

APR 5 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. K. Mullen, M. D.

4/15/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	4/16/ 19 30
20 UNDERTAKER	ADDRESS
E. L. Fanning & Son	1388 Lafayette

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500-Blks.

E 56206

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56206

CERTIFICATE OF DEATH

1-PLACE OF DEATH CITY OF BALTIMORE: (No.) St. Agnes Hospital (St.) 25-72 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Miller

(a) RESIDENCE NO. Sparks, Md (St.) Balto. Md (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Emma Miller

6 DATE OF BIRTH (month, day, and year): Nov 15th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Agent R R

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna R R

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER Henry Millar

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Eliza Barker

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Unknown

14 Informant (Address): Harry Miller Sparks. Md

15 Filed , 19 RKH. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-15- 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/4 , 1930 , to 4-15- , 1930 ,

that I last saw him alive on 4-15 , 1930

and that death occurred, on the date stated above, at 12 19 a m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer question of Carcinoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral (Asphasia 20 min) Embolism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home. 11/18/28

Did an operation precede death? yes Date of 11/27/29 4/15/30

Was there an autopsy? no

What test confirmed diagnosis? Operation, Clinically

(Signed) Nicholas P. Donelle A.B., M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pannytown Cemetery	4/17/1930

20 UNDERTAKER Wm Cook ADDRESS 1217 E Fund St

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks

Dr Norton 888 W. Lombard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56207

CERTIFICATE OF DEATH.

129 E 56207

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Sargeant ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Lantz

(a) RESIDENCE NO. 1111 Sargeant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~or) WIFE of~~ Laura Lantz

6 DATE OF BIRTH (month, day, and year) July 27th 1855

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
74	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Lantz

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Un Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Vernon Lantz (Address) 1111 Sargeant St

15 Filed ... 19 Registrar

C HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14th 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1 1930 to Apr. 14 1930, that I last saw h— alive on Apr. 14 1930, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Gt. Nephritis

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Artio Regurgitation

(duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) F. Thaddeus Pue, M. D.

4/15 1930 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 4/17/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

1 5 1930

Spec.—1-30—M. & T.—250 Bks

Dr Benj Miller 2030 Wilkens Ave ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56208

CERTIFICATE OF DEATH.

90 E 56208

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 S Bentalou St., 50-69 WARD)

2-FULL NAME Julia E. Ruark

(a) RESIDENCE NO. 402 S. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of

or) WIFE of James E. Ruark

6 DATE OF BIRTH (month, day, and year) 2/18/1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Mack Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nancy Slocum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James E. Ruark

(Address) 402 S. Bentalou St

15 Filed 5 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15th 1930

17 I HEREBY CERTIFY, That I attended deceased from 3/1 .1930. to 4/15 .1930.

that I last saw h er alive on 4/15 .1930.

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 Wilkens ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 4/18 1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—2-29-25—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-001

CERTIFICATE OF DEATH

E 56209

E 56209

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4702 Kenwick Rd 27-53 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Robinson

(a) RESIDENCE NO. 4702 Kenwick Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	83	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Daniel Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Charlotte Herring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Alice V. Baer

(Address) 419 Woodlawn Rd.

15 Filed 1 6 1930 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan-6, 1930, to April 14, 1930, that I last saw her alive on April 13, 1930 and that death occurred, on the date stated above, at 8-30 P m.

The CAUSE OF DEATH* was as follows:

La Grippe - Acute Bronchitis

(duration) yrs. mos. 39 ds.

CONTRIBUTORY (Secondary) Senile Arterio-Sclerosis

(duration) ? yrs. mos. ?? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M. Gibson Porter, M. D.

4/15, 1930 (Address) 4822 Roland Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemy.	April 16, 1930
20 UNDERTAKER	ADDRESS
John A. Mitchell & Son	1600 Eutaw St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 56210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. 13 1255 E 56210

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 St Paul ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Beirne Bathbone

(a) RESIDENCE NO. 2124 St Paul ST., 12 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 67 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced RUSBAND of (or) WIFE of Camden Bathbone

6 DATE OF BIRTH (month, day, and year) About 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	About 67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Parkersburg West Va.

PARENTS

10 NAME OF FATHER Thos Blackford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lynchburg Virginia

12 MAIDEN NAME OF MOTHER Harriet Murdock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Parkersburg W. Va.

14 Informant Mrs Lulu Adams (Daughter)
(Address) 12 West Preston St

15 Filed APR 16 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept 28, 1925 to April 15, 1930.

that I last saw h e alive on April 15, 1930

and that death occurred, on the date stated above, at 11.05 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia
{Chr. arteriosclerosis (Supp.)
Chr. pyelonephritis}

(duration) 2 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chr. atherosclerosis & hypertension
Chr. pyelonephritis (duration) 1 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of no

Was there an autopsy? no Was diagnosis confirmed by clinical findings?

What test confirmed diagnosis? physical diagnosis

(Signed) Nathaniel M Beck, M. D.

19 (Address) 1006 E. 23rd St Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL Apl 17 19 30

20 UNDERTAKER Stewart & Company

ADDRESS Balto.

Form 1-30—M. A. T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 56211

CERTIFICATE OF DEATH.

E 56211

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 18-16 WARD)

2-FULL NAME Robert Jones

(a) RESIDENCE NO. 806 W Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Jones

6 DATE OF BIRTH (month, day, and year) June 14-1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Handy Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Record (Address)

15 Filed R 16 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-30

17 I HEREBY CERTIFY, That I attended deceased from 3-17, 1930, to 4-15, 1930, that I last saw him alive on 4-15, 1930, and that death occurred, on the date stated above, at 2 10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial fistula

Empyema right chest

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 3-23-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Lumpkin, M. D.

4-16 1930 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carey N. C.

DATE OF BURIAL 4-16 1930

20 UNDERTAKER Edward Taylor

ADDRESS 916 Dolphin

Spec.—1-30—M. & T.—250 Blks.

E 56212 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 E 56212

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp. St., 4-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Monroe

(a) RESIDENCE NO. 617 Carrick ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-18-06

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Monroe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lavinia Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Record

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14-30

17 I HEREBY CERTIFY, That I attended deceased from 4-12, 1930, to 4-14, 1930, that I last saw h.e alive on 4-14, 1930, and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pelvic inflammatory disease

(duration) yrs. mos 7 da.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

4-16, 1930 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Maulsby Ave

DATE OF BURIAL 4-16 1930

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa Ave

Spec.—1-10-21—MAT—1500 Blks.

E 56213

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56213

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2704 Mosher ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Schriefer

(a) RESIDENCE NO. 2704 Mosher ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7th 1855

7 AGE: Years 74 Months 9 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Downing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Minnie Emohundro

(Address) 2704 Mosher st

15 Filed APR 16 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1930

17 I HEREBY CERTIFY That I attended deceased from Apr 7 1930 to Apr 14 1930, that I last saw her alive on Apr 13 1930, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 2 or 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) M Bannenstock, M. D.

4/15/1930 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: April 17th 1930

20 UNDERTAKER: A. Jones — ADDRESS: 111 S. Gilmor St

TION is very important See instructions on back of certificate.

Spec.—2-20-28—L. F. S.—500 Bks.

E 56214

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56214

16-002

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 847 W Lexington ST. 16-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Smith

(a) RESIDENCE NO. 847 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 3 mos. da. How long in U. S., If foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	1905 aug.	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Manfield Kerney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Matilda Kinno

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mary Holmes

(Address) 1117 Laughton Ave

15 Filed ____ 19____ HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14/30

17 I HEREBY CERTIFY, That I attended deceased from Feby 4. 1930. to Apr. 12. 1930

that I last saw h er alive on Apr. 12 - 1930

and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. 14 da.

CONTRIBUTORY (Secondary) Neuritis & Stomatitis

(duration) yrs. 2 mos. 14 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? medical

(Signed) L. Hibaltar M. D.

19 (Address) 1438 St George Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: April 18 1930

20 UNDERTAKER: L. L. Brown & Son

ADDRESS: 1818 W. Mondy St

Spec.—1-30—M. & T.—250 Bks.

E 56215

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 56215

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1534 Holbrook St (Ward) 9-18

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Jenkins

(a) RESIDENCE NO. 1534 Holbrook St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Sept 4 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles H Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma Wallhausen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Charles H Jenkins

(Address) 1534 Holbrook St

15 Filed APR 16 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to April 13, 1930, that I last saw her alive on April 13, 1930 and that death occurred, on the date stated above, at 11.05 P. m.

The CAUSE OF DEATH was as follows:

Broncho-pneumonia

(duration) yrs. mos 9 da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel B Wolfe, M. D.

4/15, 1930 (Address) 1331 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 4/16 1930

20 UNDERTAKER Mary T. Ruth Sons

ADDRESS 1733 Bayard Ave

Cor.—10-10-29—A Co.—100 Bks.

56216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-703

E 56216

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Union Mem. Hosp. St. 12-50 Ward)

2-FULL NAME Lawrence F. Fuller

(a) RESIDENCE NO. 2614 Greenmount St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 26 1914

7 AGE: Years 15 | Months 4 | Days 17 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Grocery
(b) General nature of industry, business, or establishment in which employed (or employer): Store Clerk
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Baltimore

PARENTS

10 NAME OF FATHER Fred Fuller

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER Nellie Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant Mrs. Fred Fuller
(Address) 2614 Greenmount Avenue

15 Filed APR 16 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto accident in which he was a rider & he lost control of driver and overturned Car

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Gallaway Valley Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

4/15 1930 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	4/17 1930
20 UNDERTAKER Mary T. Ruth	ADDRESS 1735 Harford Ave

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 56217 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56217

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital REGISTERED NO. 18-134

CITY OF BALTIMORE: (No. 515 Arlington Ave ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harriett Watts

(a) RESIDENCE NO. 515 N. Arlington Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas H Watts

6 DATE OF BIRTH (month, day, and year) Mar 827

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Abdock Bailor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Hannah Bailor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Chas H Watts

(Address) 515 N Arlington Ave

15 Filed ... 19... Registrar C. HAMPTON JONES, M. D.

APR 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-30

17 I HEREBY CERTIFY, That I attended deceased from 3-17- 1930, to 4-15- 1930,

that I last saw h alive on 4-15- 1930

and that death occurred, on the date stated above, at 1:35 p. m.

The CAUSE OF DEATH* was as follows:

Potts disease

Spinal abscess Tuberculosis

Duration yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical X. Ray.

(Signed) A Hartsock, M. D.

4/15 1930 (Address) 600 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr Auburn

DATE OF BURIAL April 18 1930

UNDERTAKER Thomas E Wright

ADDRESS 700 N Carrollton Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 56218

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 56218

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 211 N. Fulton Ave ST. 4th WARD)

2—FULL NAME Charles A. Klunk

(a) RESIDENCE NO. 211 N. Fulton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 2 mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Mary E. Klunk

6 DATE OF BIRTH (month, day, and year): Feb 19 1876

7 AGE: Years 54 Months 2 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Telegraph Operator

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer: B. O R. Road

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Martin Klunk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Ellen M. Streaks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: James L. Klunk

(Address): 1801 Aisquith St City

15 Filed APR 16 1930 19 Per ____ Registrar

C. HAMPTON JONES, JR.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 1930

17 I HEREBY CERTIFY, That I attended deceased from March 30, 19 30, to April 15, 19 30,

that I last saw h[illegible] alive on April 14, 19 30,

and that death occurred, on the date stated above, at 3 15 a. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary tuberculosis

(duration) 1 yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

4/15, 19 30 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Apr 17 1930
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	2173 Bway

Spec.—1-10-21—M&T—1500 Blks.

E 56219

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56219

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1363 N Carey ST. 15-22 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mate Thomas Williams

(a) RESIDENCE NO. 1363 N Carey ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Paul Williams

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lanier Dano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) William Jackson 1363 Carey St. Balto. Md.

15 Filed 19 Per Registrar

C. HAMP...

PRT 6 193...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 19 30

17

I HEREBY CERTIFY, That I attended deceased from Sept 1X, 1929, to April 17, 1930,

that I last saw her alive on April 1, 1930,

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey M. D.

April 17, 1930 (Address) 1927 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL

Woodlawn Mem. Park Cem. April 19 30

20 UNDERTAKER | ADDRESS

Virginia A Brooks | 1463 N Carey

TION is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56220

CERTIFICATE OF DEATH.

179

E 56220

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2907 c Silsa Ave WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Krautter

(a) RESIDENCE NO. (Usual place of abode) 2907 c Silsa Ave ST., WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Krautter

6 DATE OF BIRTH (month, day, and year) July 22/1864

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Fred Krautter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosanna Wiedt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Anna Krautter (Address) 2907 c Silsa Ave

15 Filed ... 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1930 to April 15, 1930.

that I last saw him alive on April 14, 1930 and that death occurred, on the date stated above, at 12.45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Bruck, M. D.

19 (Address) 706 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	Apr 18, 30
20 UNDERTAKER Philip Henry	ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56221

CERTIFICATE OF DEATH

E 56221

REGISTERED NO. 21-29

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1168 Cleveland ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James S. T. Needing

(a) RESIDENCE NO. 1168 Cleveland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Needing

6 DATE OF BIRTH (month, day, and year): Feb 7. 1903

7 AGE: Years 27 | Months 2. | Days 7. | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printing Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Montgomery Ward

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Paul Needing

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Matilda E. Shlag

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Paul Needing

(Address) 1168 Cleveland St

15 Filed ... 19 ... C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 14 30

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to April 14, 1930, that I last saw h— alive on April 13, 1930 and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Alcoholism (duration) — yrs 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clin.

(Signed) Edw Emerson, M. D.

4/15, 1930 (Address) 517 Fenton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. — DATE OF BURIAL: Apr 17 1930.

20 UNDERTAKER: Mr Mrs John W. Geisel & Son — ADDRESS: 801 W. Fayette

Spec.—8-16-29—L. F. S.—100 Bks.

E56222. 129 ✓ E 56222

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 1[illegible]-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W. Coulbourn

(a) RESIDENCE NO. 1309 W. Fayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. d[redacted]w long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Coulbourn

6 DATE OF BIRTH (month, day, and year) April 10, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36		4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Oriole Md.

PARENTS

10 NAME OF FATHER George Coulbourn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oriole Md

12 MAIDEN NAME OF MOTHER Margaret Elzy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Oriole md

14 Informant Lillian Coulbourn

(Address) 1309 W. Fayette St.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 14, 1930.

17 I HEREBY CERTIFY, That I attended deceased from Apl. 4, 1930 to Apl. 14, 1930.

that I last saw h[illegible] alive on Apl. 14 1930

and that death occurred, on the date stated above, at 8.25 [illegible]

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. 1 mos. 21 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis &. Hypertension Heart Disease (duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) R. H. Carlson M. D.

4 14 1930 (Address) 6010 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL April 17, 1930

20 UNDERTAKER Mr. Katie R. Williams

ADDRESS 3221 Schroeder St.

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56223

CERTIFICATE OF DEATH

REGISTERED NO. E 56223

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 W Fairmount ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alex. Wright

(a) RESIDENCE NO. 1034 W Fairmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie M. Wright

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto md.

9 BIRTHPLACE (city or town) (State or country): Balto md.

PARENTS

10 NAME OF FATHER: Luther Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Lizzie Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Carrie M. Wright

(Address) 1034 W Fairmount

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1930

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1930, to April 13, 1930, that I last saw h... alive on April 13, 1930, and that death occurred, on the date stated above, at 11 P. ... m.

The CAUSE OF DEATH was as follows:* Pulmonary Tuberculosis

(duration) yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary): Pulm. Oedema (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Norwood M. D.

April 15, 1930 (Address) 909 W Fayette

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: April 17, 1930

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 3224 Edmondson Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56224 — CERTIFICATE OF DEATH. — 90 E 56224

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 738 George St., 17-24 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Jones

(a) RESIDENCE NO. 738 George ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 6, 1863 (4-1859)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Henry Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Jennie Brent

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Georgia Robinson
(Address): 738 George St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 15 1930

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1930, to Apr 15, 1930, that I last saw h[illegible] alive on Apr 14, 1930 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Yes

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. B. Hughes, M. D.

4/16 1930 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Md.

DATE OF BURIAL: 4/17 1930

20 UNDERTAKER: Samuel E. Hawley

ADDRESS: Laurel Md

21

TION is very important. See instructions on back of certificate.

Spec—1-30—M. & T.—250 Bks.

Shields

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56225

E 56225

46

CERTIFICATE OF DEATH.

14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Druid Hill Ave ST. WARD)

2-FULL NAME Lena L Shields

(a) RESIDENCE NO. 1521 Druid Hill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer Smith

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Hamilton

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. E. Hutchinson
(Address) 521 Druid Hill Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 15 1930

17 I HEREBY CERTIFY, That I attended deceased from June 2nd, 1924, to April 15th, 1930, that I last saw her alive on April 9th, 1930, and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus and adnexa

(duration) yrs. 11 mos 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Kimmell Fangt, M. D.

, 19 (Address) 2937 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

DATE OF BURIAL 4/17 19 30

20 UNDERTAKER Thos. E. Bowley

ADDRESS 5700 Belair Rd

Spec. 1-30 M. & T.—250 Blks.

E 56226

E 56226 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

REGISTERED NO. 17124

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1204 Argyle Ave ST. (Ward) 17

2-FULL NAME Grace L. Wise

(a) RESIDENCE NO. 1204 Argyle Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Color	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Louis E. Adams 412 Argyle Ave

15 Filed ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17-1930.

17 I HEREBY CERTIFY, That I attended deceased from April 10 19 30 to April 15 19 30, that I last saw her alive on April 17 19 ..... and that death occurred, on the date stated above, at 11-30 A m.

The CAUSE OF DEATH* was as follows: Paralysis Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTOR (Secondary) Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. R. Finton M. D.

April 19 31 (Address) 1212 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 4/17 19 30

20 UNDERTAKER Samuel K. Handley

ADDRESS 1 E Eddy

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56227

CERTIFICATE OF DEATH.

129 B 56227

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3420 Garrison Blvd. (WARD) 54-64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian J. Boone

(a) RESIDENCE NO. 3420 Garrison Blvd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W. H. Boone

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	4	17 18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James L. Duff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hattie Jessup

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. W. H. Boone

(Address) 3420 Garrison Blvd.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 11, 1930, to Apr 14, 1930,

that I last saw her alive on April 13, 1930,

and that death occurred, on the date stated above, at 11.35 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

arterio-sclerosis

from history (duration) 2 yrs. ... mos ... da.

CONTRIBUTORY (Secondary) myocarditis about (duration) ... yrs. 6 mos. ... da.

18 Where was disease contracted if not at place of death? --------

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Thos. S. Wiblin M. D.

4/5, 1930 (Address) 222 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Apr. 17 1930
20 UNDERTAKER Wm. J. Pickersons Sons	ADDRESS North Pa

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56228

E 56228

CERTIFICATE OF DEATH.

86-001

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 425 St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Percy W. Lauder

(a) RESIDENCE NO. Rennert Hotel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	~~Widower~~ Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of Mabel Lauder

6 DATE OF BIRTH (month, day, and year) Sept 1, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Tillett & Co. Bankers

9 BIRTHPLACE (city or town) Portland

(State or country) Md.

PARENTS

10 NAME OF FATHER Saml M. Lauder

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Gertrude L. Crabbe

13 BIRTHPLACE OF MOTHER (city or town) La.

(State or country)

14 Informant Mr. Barrett P. Lauder

(Address) Chicago Ill

15 Filed APR 6 1930 M. Fabian (JOHN S. M.) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15/30

17 I HEREBY CERTIFY, That I attended deceased from 4/14/30, 19..., to 4/15/30, 19...,

that I last saw him alive on 4/15/30, 19...,

and that death occurred, on the date stated above, at 2-30 A. m.

The CAUSE OF DEATH* was as follows:

Meningetes (Type 2 pneumococcus)

(duration) ... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Ac Otitis Media

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? at Large

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Turner, M. D.

4/16/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL Apl 18 1930

20 UNDERTAKER Wm. J. Fletcher Sons ADDRESS North Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56229

CERTIFICATE OF DEATH

90 E 56229

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2510 W Fayette ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida F Farley

(a) RESIDENCE NO. 2510 W Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Tom Seymour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Nathaniel W Farley

(Address) 2510 W Fayette St

FILED 4 16 1930 C. HAROLD WILLIS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/13 1930 to 4/15 1930

that I last saw h alive on 4/15 1930

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism Thrombosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 6 yrs 1 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure

(Signed) Chas A Cain M. D.

4/15 1930 (Address) 2145 N Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Apr 17 1930

UNDERTAKER J Vernon Keehner ADDRESS 153 Hollins

Spec.—1-12-23—M&T—500 Blks.

E 56230 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 56230

CERTIFICATE OF DEATH. 124

REGISTERED NO. 16-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1119 W. Lanvale St. (Ward)

2-FULL NAME Martha C. Lewis

(a) RESIDENCE NO. 1119 W. Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Lewis

6 DATE OF BIRTH (month, day, and year) Mar 6, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	64	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Eliza Mosely

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Helen A. Tripp (Address) 11 N. Lanvale St

15 Filed 1930 H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 8 1930 to Apr 13 1930, that I last saw h[illegible] alive on Apr 13 1930 and that death occurred, on the date stated above, at 2 a m

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Vascular Renal Disease ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S B Hughes M. D.

4.14.1930 (Address) 1413 D. Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lincoln Memorial Cemetery, Md.	April 17 1930
20 UNDERTAKER Mr. Nate R. Williams	ADDRESS 3227 Edmondson

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56231

E 56231

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 625 Forney Alley St., 4-25 Ward)

2-FULL NAME Andrew Scott

(a) RESIDENCE NO. 625 Forney Alley St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Scott

6 DATE OF BIRTH (month, day, and year) Apr. 3 - 1889.

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or ... min.
	40	6	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER David Scott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER May E. Treherne

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Mrs. H. Scott
(Address) 625 Forney Alley

15 Filed ... 19... ... Registrar

APR 16 1930

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhagic Pancreatitis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Augustus Gilbert M. D.

4/15. 1930 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 17 1930
20 UNDERTAKER	ADDRESS 321 N. Schroeder St.
Mrs Kate R. Williams	

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56232

CERTIFICATE OF DEATH.

100-82

E 56232

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 928 S. Kenwood Avenue St. 1-3 Ward)

2-FULL NAME Anna . Nikonczuk

(a) RESIDENCE NO. 928 S. Kenwood Avenue St. 1 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		10	17	16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Michael . Nikonczuk

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Stanislawa.Wilczynska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Stanislawa . Nikonczuk Mother

(Address) 928 S Kenwood ave

15 Filed APR 16 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, au-topsy or inquiry) find that said deceased came to death on the day stated above. 10:5 PM

The CAUSE OF DEATH* was as follows:

Lobar Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

Apr 16 30 (Signed) C. Hampson Jones M. D.

(Coroner)

(Address) 1-3 S Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where disease was contracted, if not at place of death

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery Date of Burial April 16 1930

20 UNDERTAKER John M Weber ADDRESS 401 S Chester St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

182

E 56233

CERTIFICATE OF DEATH

E 56233

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Unknown Pier # 7 Balt St. 4-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME " " "

(a) RESIDENCE NO. " " St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 089
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

Filed ..... 19.. Registrar

S. HAMPSON JONES, M. D.

APR 6 1930

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
on the 4 day of Apr 1930, and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:*
Acc? Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Findings Just Glance, M. D.
19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY.	19
20 UNDERTAKER Commissioner Health	ADDRESS

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 56234

E 56234

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 17-24 Ward)

2-FULL NAME Arthur Gibbs

(a) RESIDENCE NO. 710 D Hill St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Black	don't Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..., 19.. Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes
Pneumonia.

Contributory Exhaustion (duration) 1 yrs. mos. 7 ds.

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm E Gladden M. D.

, 19 (Address) 1336 Bro

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

Per Wm E Goodall

UNIVERSITY OF MARYLAND
HISTORICAL COLLECTIONS
APR 16 1930

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56235

CERTIFICATE OF DEATH

90

E 56235

REGISTERED NO.

1-PLACE OF DEATH 2 Lecty Hospital

City of Baltimore: (No. ~~2 Forest Avenue~~ St., 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard Loring

(a) RESIDENCE NO. 623 N Port St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	dont Know

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 087
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 6 mos. 7 da.

CONTRIBUTORY (Secondary) Cirrhosis

(duration) yrs. mos. da.

18 Where was disease contracted — —
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm G Brady, M. D.

, 19 (Address) 143 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
UNIVERSITY OF MARYLAND

DATE OF BURIAL
19

20 UNDERTAKER
Commissioner Health

ADDRESS
APR 16 1930

important. See instructions on back of certificate.

THE MORGUE

Par. Wm. E. Woods

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56236

CERTIFICATE OF DEATH

90 E 56236

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Somerset Rd. ST. 27-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Oldham

(a) RESIDENCE NO. 610 Somerset Rd. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: Frederick Oldham

6 DATE OF BIRTH (month, day, and year): May 1, 1861

7 AGE — Years: 68 — Months: 11 — Days: 14 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: John R Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Carrie O. Hylton

(Address) 610 Somerset Rd.

15 Filed 1 6 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15, 1930

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to April 15, 1930, that I last saw h Er alive on April 15, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry T. Collenberg, M. D.

Apr. 16, 1930 (Address) 901 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemy.	April 17, 1930
20 UNDERTAKER	ADDRESS
Chas O. Mitchell & Sons	1900 Eutaw St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56237

CERTIFICATE OF DEATH

E 56237

129

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2200 Arden Road ST.) 27-54 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James E. Dieffenderfer

(a) RESIDENCE NO. 2200 Arden Road ST., _____ WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 8 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances K. Dieffenderfer

6 DATE OF BIRTH (month, day, and year) Aug. 12-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Claim Reporter

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Fuel Co.

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James P. Dieffenderfer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mollie Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Frances K. Dieffenderfer

(Address) 2200 Arden Road

15 Filed ... C. HAMPSON JONES, M. D. Registrar

APR 16 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14-1930.

17 I HEREBY CERTIFY, That I attended deceased from March 25 1930, to Apr. 14 1930,

that I last saw him alive on Apr. 14 1930,

and that death occurred, on the date stated above, at 4 45 P. m.

The CAUSE OF DEATH* was as follows:

Uremia - Chr. Interstitial Nephritis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Uremia

(Signed) Harry E. Tilson, M. D.

, 19 (Address) 3 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL April 17 1930.

20 UNDERTAKER Horace F. Burgee — ADDRESS 3631 Falls Road

Spec.—1-10-21—MAT—1500 Blks.

E 56238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56238

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank W. Kernon

(a) RESIDENCE NO. 1805 E. Chase St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs F. W. Kernon/864

6 DATE OF BIRTH (month, day, and year) Sept 18th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65?	8 6	15 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Wm. F. Kernon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliz. Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Md. Gen. Hosp.

15 Filed 1 6 1930 . 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1930

17

I HEREBY CERTIFY, That I attended deceased from April 8 . 1930 . to April 15 . 1930.

that I last saw h alive on April 15 . 1930.

and that death occurred, on the date stated above, at 8 55 p. m.

The CAUSE OF DEATH* was as follows:

Ch. Parenchymatous nephritis.

Hydropericardium?

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia ?

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical.

4/16/30 (Signed) Jno A Kemp M. D.

. 19 (Address) 1715 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loraine Cemetery	4-18 1930

20 UNDERTAKER Wm Cook ADDRESS 1211 St Paul St.

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. P. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56239 123 E 56239

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No.) Lombard & Greene Sts. (WARD) 17th

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Oldia Sills

(a) RESIDENCE NO. 2410 Barclay St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: O Donnell Sills

6 DATE OF BIRTH (month, day, and year): Sept 28, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
28	29	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Geo. Fagan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ella Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: O Donnell Sills

(Address) 2410 Barclay St.

15 Filed APR 16 1930, 19 ... Registrar

HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/14/30

17 I HEREBY CERTIFY, That I attended deceased from 4/11/30, 19..., to 4/14/30 19..., that I last saw her alive on 4/14/30 19..., and that death occurred, on the date stated above, at 9 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac failure

Empyema of Gall bladder

with gall Stone

(duration) symptoms yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Operation Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/13/30

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation and Operation

(Signed) J. E. Deaver, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: April 7 1930

20 UNDERTAKER: W. M. Rooter

ADDRESS 223 5th Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56240

1871 E 007 56240

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

I-PLACE OF DEATH

City of Baltimore: (No. University Hospital 16-22 (Ward)

2-FULL NAME George Pinkney

(a) RESIDENCE NO. 1003 N. Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Pinkney

6 DATE OF BIRTH (month, day, and year): 1902

7 AGE: Years 28; Months; Days; IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 040
(c) Name of employer: General Refractories Co

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: James Pinkney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary E. Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

PARENTS

14 Informant: Mrs. M. Pinkney (Address) 1003 N. Mount St.

15 Filed: 6 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Laceration of right arm, shoulder & axilla. Fracture right clavicle. Accidental (over) Death. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fairfield, Md. Date of 3/31/30.

Did an operation precede death? Yes

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Microscopic

(Signed) Eugene Feller M. D.

4/16, 1930 (Address) 2157 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 4-17 1930

20 UNDERTAKER: Geo. H. Jones

ADDRESS 1027 Hollins

important. See instructions on back of certificate.

Rev.—12-23-21—E.B.R.S.—400 Blks.

E 56241

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56241

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 Park Ave St. 11-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Jackson

(a) Residence No. 1113 Park Ave St, Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Col

~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6-DATE OF BIRTH (month, day and year)

7-AGE: 83 yrs. ✓ mos. ✓ ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Saml. Jackson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Edith Brooks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14- (Informant) Edith Travers

(Address) 1709 Whitehall St

15-

Filed ..... 193.....

Registrar.

6 1930

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): April 11-1930

17- I HEREBY CERTIFY, That I attended deceased from April 9 1930 to April 15 1930.

that I last saw him alive on April 11 1930

and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelletreau M. D.

19 (Address) 617 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: [redacted]. Arbor

DATE OF BURIAL. 4-15 1930

20-UNDERTAKER: J. C. [redacted] Jordan

ADDRESS 1127 Hendrix

Spec.—2-29-28—L. F. S.—500 Bks.

E 56242 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 56242

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1030 Vine ST. 18-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Brittingham

(a) RESIDENCE NO. 1030 Vine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank McDowell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary McDowell

(Address) 533 Grassmere Ave

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15/30

17 I HEREBY CERTIFY, That I attended deceased from 4/12/30, to 4/15/30,

that I last saw her alive on 4/14/30,

and that death occurred, on the date stated above, at 1.52 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Primary)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W S Hamilton M. D.

4/15/1930 (Address) 912 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn

DATE OF BURIAL 4-17 1930

20 UNDERTAKER John N. Jordan

ADDRESS 627 Lombard

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56243

CERTIFICATE OF DEATH.

E 56243

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Park Ave ST. 11-24 WARD)

2-FULL NAME Willie B. Simmons

(a) RESIDENCE NO. 710 Park Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER George P Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER C. M. Blake

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs L Simmons
(Address) 710 Park Ave

15 Filed ... 19 ... C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th 1930

17 I HEREBY CERTIFY, That I attended deceased from July 11 1930, to Apr 16 1930,
that I last saw her alive on Apr. 16 1930,
and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of the Stomach

(duration) 3 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary): None Known
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? no.

What test confirmed diagnosis? Phys exam

(Signed) Chas J Keller M. D.

(Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	April 18 1930
20 UNDERTAKER: Henry Perkins Sons	ADDRESS: Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56244

CERTIFICATE OF DEATH

E 56244

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1042 N. Stockton St., 16-23 (Ward)

2-FULL NAME Warren Rich

(a) RESIDENCE NO. 1042 N. Stockton St., Ward Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 Color or Race Wh | 5 Single, Married, Widowed or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene Rich

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or ... min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country) "

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible]
(State or country)

14 Informant Phillip Rich
(Address) 1042 N. Stockton

15 Filed ... 19 ... G. HAMPSON JONES, M. D. Registrar

16 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.
(Address) [illegible] Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem.

DATE OF BURIAL 4-19 1930

20 UNDERTAKER George T. A. Gibson

ADDRESS 1785 Louisiana

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56245

CERTIFICATE OF DEATH

111-002

E 56245

REGISTERED NO.

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 16-67 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marshall P. Holman

(a) RESIDENCE NO. 767 Linard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace D Holman

6 DATE OF BIRTH (month, day, and year) Aug 15, 187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Supt

(b) General nature of industry, business, or establishment in which employed (or employer) Dining Service

(c) Name of employer Pullman Car Co

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Isaac N Holman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada

12 MAIDEN NAME OF MOTHER Isabella Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant Mrs Grace D Holman

(Address) 767 Linard St

15 Filed APR 16 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1930

17 I HEREBY CERTIFY, That I attended deceased from April 12 1930, to April 16 1930, that I last saw h alive on April 16 1930 and that death occurred, on the date stated above, at 5-30 P. m.

The CAUSE OF DEATH* was as follows:

Duodenal ulcer

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1920

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs + symptoms

(Signed) Samuel T Hetrick, M. D.

19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL APR 18 1930

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56246

CERTIFICATE OF DEATH.

18 VE 56246

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot of Wolfe St. 2-4 Ward)

2-FULL NAME John Wujek

(a) RESIDENCE NO. 1733 Lancaster St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Sept 29 1921

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	8	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) School Boy

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adam Wujek

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Poland

12 MAIDEN NAME OF MOTHER Albina Jazwinska

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Poland

14 Informant Adam Wujek

(Address) 1733 Lancaster St.

15 Filed _____ C. HAMPSON JONES, M. D. Registrar

6 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death at the day stated above.

The CAUSE OF DEATH* was as follows:

Acc. Drowning

(Duration) ____ yrs. ____ mos. — ds.

CONTRIBUTORY (Secondary) No Physician

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. C. Gibbs M. D.

(Coroner)

19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Former or usual residence.....

Where was disease contracted, if not at place of death?.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem. April 18, 30 Date of Burial

20 UNDERTAKER John M Weber 401 S. Chester St. ADDRESS

Instructions: Fill in all blanks with the best information obtainable. Be sure that the personal and statistical particulars and the medical certificate of death are complete and correct. Write plainly with pen and ink and use the word "None" where there is no answer to an item. Do not use ditto marks. Sign and return this certificate to the undertaker. See instructions on back of certificate. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20 are very important.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ E 56247

E 56247

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3407 Dupont Ave (St.) 27-56 (Ward)

2-FULL NAME Rose Morris

(a) RESIDENCE NO. 3407 Dupont Ave St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late James F. Morris

6 DATE OF BIRTH (month, day, and year) 6-1766

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	63	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co (State or country) Md

PARENTS

10 NAME OF FATHER L. Gugel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary E. Morris (Address) 3407 Dupont Ave

15 Filed APR 7 1930 19 HAROLD JAMES, M. D. Registrar Ralph H.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tobacco Amblyopia

Heart (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) (duration) .....yrs. .....mos. .....ds.

(Signed) Chas. F. Morrison M. D. (Coroner)

4/16, 1930 (Address) 732 Poplar Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs.. ....mos.. ....ds. In the State ....yrs.. ....mos.. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial 4/17/30

20 UNDERTAKER Geo. Wilbur & Son ADDRESS 2503 Edmondson Ave

Very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 56248 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 117 ✓ E 56248

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. David Pisareck

(a) RESIDENCE NO. 444 S. Smallwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mns. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stella

6 DATE OF BIRTH (month, day, and year) No. 1899

7 AGE	31 Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Adom Pisareck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) No.

14 Informant M. Pisareck

(Address) 444 S Smallwood St.

15 Filed APR 7 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15-1930

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to April 15, 1930, that I last saw him alive on April 15, 1930 and that death occurred, on the date stated above, at 8 45 P m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis, Ruptured

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) General Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of April 14, '30

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Operative

(Signed) J. H. Jenquin, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Russia Independet — DATE OF BURIAL: April 18, 1930

20 UNDERTAKER: John Grebliauckas J. G. — ADDRESS: 423 S Paca St.

Cor.—10-10-29—A Co.—100 Bks.

E 56249

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56249

CERTIFICATE OF DEATH

74-001

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2822 Belmont St. 16-68 Ward)

2-FULL NAME Frank H. McLeod

(a) RESIDENCE NO. 2822 Belmont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie

6 DATE OF BIRTH (month, day, and year) July 27 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	56	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Soldier
(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Army
(c) Name of employer Phila Pa.

9 BIRTHPLACE (city or town) Phila Pa.
(State or country)

PARENTS

10 NAME OF FATHER Frank H. McLeod

11 BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or country)

12 MAIDEN NAME OF MOTHER Sophie

13 BIRTHPLACE OF MOTHER (city or town) Phila.
(State or country)

14 Informant Mary Bretton
(Address) 2822 Belmont St. B

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Apr 16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. H. Schaulz M. D.

Apr 15 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	April 19 1930
20 UNDERTAKER Chas. F. Stearns	ADDRESS 1512 Park Ave

important. See instructions on back of certificate.

Spec.—3-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56250

CERTIFICATE OF DEATH

8-17 129 ✓ E 56250

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Edgewood Sanitarium (WARD) Baltimore Co. Gorsuch

2—FULL NAME George Nosset Sr

(a) RESIDENCE NO. 1442 N. Gay ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret F Nosset

6 DATE OF BIRTH (month, day, and year): Sept 15 1859

7 AGE: Years 70 | Months 6 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fredericksburg Va

PARENTS

10 NAME OF FATHER: Wm Nosset

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredericksburg Va

12 MAIDEN NAME OF MOTHER: Sallie Waite

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va Brown

14 Informant: George Nosset

(Address) 1442 N. Gay ST

15 Filed [illegible] 19 [illegible] Registrar

1 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-16-30

17 I HEREBY CERTIFY, That I attended deceased from Nov 12 1929 to April 16 1930

that I last saw him alive on 4-15 1930

and that death occurred, on the date stated above, at 7 AM m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation
Chronic Interstitial Nephritis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration
(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs,

(Signed) David Miller M. D.

4/16 1930 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	April 19 1930
20 UNDERTAKER	ADDRESS 1203
Henry Lutz	Broadway

Spec.—1-30—M. & T.—250 Blks.

56251

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

× 90 E 56251

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE. (No.) 2203 E. Biddle ST. 8-12 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ferdinand Schwartz

(a) RESIDENCE NO. 1617 Potomac Ave. S.E. Washington D.C. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? 50 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Schwartz

6 DATE OF BIRTH (month, day, and year) Dec. 14 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	76	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS
10 NAME OF FATHER Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known
12 MAIDEN NAME OF MOTHER Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Joseph Evans
(Address) 2263 E. Biddle St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 16 1930

17 I HEREBY CERTIFY, That I attended deceased from March 8 19 30 to April 16 19 30
that I last saw ~~him~~ alive on April 15 19 30
and that death occurred, on the date stated above, at 10:45 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease 1 mo. 8 da.
(duration) yrs.
Bronchitis
CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington, D.C.
Did an operation precede death? No Date of
Was there an autopsy? No
What tests confirmed diagnosis? Clinical
(Signed) Walter A. Meyer M. D.
17, 19 30 (Address) 1031 N. Caroline str.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Apr. 19 1930
20 UNDERTAKER Henry Nowell Sons ADDRESS 1301 E Eager St

Spec. 2-29-28—L. F. S.—500 Blks.

E 56252

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56252

REGISTERED NO. 1296

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. (WARD) 26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Sophia May

(a) RESIDENCE NO. 1212 W. Cross St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Chas May

6 DATE OF BIRTH (month, day, and year) 4-12-1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas May (Address) 1212 W Cross St

15 Filed ... Registrar

APR 7 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/30

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to April 16, 1930, that I last saw her alive on April 16, 1930, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis with shock

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardio-Vascular Renal Dis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 4-14-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical picture

(Signed) Arthur Rattenni M. D.

4/16 1930 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL 4/19/30 19

20 UNDERTAKER: Crescent Co

ADDRESS 525 Lynch

Cor.—10-10-29—A Co.—100 Blks.

Edw Walton

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56253 ✓ E 56253

CERTIFICATE OF DEATH

E 56253

1-PLACE OF DEATH

City of Baltimore: (No. City Jail St. 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Walton

(a) RESIDENCE NO. Edgehill 1220 St. Paltimore Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed or Divorced, (write the word): Married

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of: M.

6 DATE OF BIRTH (month, day, and year): July 9th-1892

7 AGE: Years 38 | Months 9 | Days 6 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Edward Walton

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Hannah Black

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Jos Walton
(Address) 1220 Bonney

Filed 11-7 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure
Arteriosclerosis
Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. J. Peters Coroner M. D.

Oct. 13 1930 (Address) 16 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Cemetery — DATE OF BURIAL: Oct 17. 1930

20 UNDERTAKER: Fred A. Schweitzer — ADDRESS: 703 Hanover St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 56254

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 E 56254

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 West North Ave. ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Sass

(a) RESIDENCE NO. 745 West North Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Sass

6 DATE OF BIRTH (month, day, and year) Dec. 13th. 1851.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Hirsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Miss. E. Sass

(Address) 745 W. North Ave

APR 17 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1928, to April 16, 1930, that I last saw h[er] alive on April 16, 1930 and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

carcinoma of the oesophagus.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray.

(Signed) Samuel Hirsch M. D.

, 19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oheb Shalom Cem.

DATE OF BURIAL 4/17/ 1930

20 UNDERTAKER Ward Sondheim

ADDRESS 118-20 W. Mt Royal Ave

Spec.—8-16-29—L. F. S.—100 Bks.

E 56255
23600

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56255
31 V

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JONES HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Osborne

(a) RESIDENCE NO. 624 N. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	Infant

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ....

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel
(State or country) County Maryland

PARENTS

10 NAME OF FATHER George Osborne

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country) Md

14 Informant Records
(Address)

15 Filed ...., 19 30 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16-1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to April 16, 1930

that I last saw him alive on April 16, 1930

and that death occurred, on the date stated above, at 5 45 m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) .... yrs. .... mos. 2 ds.

CONTRIBUTORY (Secondary) Tbc.

(duration) .... yrs. 4 mos. .... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) J. R. Eickford, M. D.

4/16 1930 (Address) JHH.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Magothy A. A. Co. Md	April 17 1930

20 UNDERTAKER Robert W. Sullivan ADDRESS 1515 W. McElderry St

JOHNS HOPKINS HOSPITAL
APR 17 1930
HAMPSON JONES

Spec.—130—M. & T.—250 Blks.

Hardin

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56256

E 56256

CERTIFICATE OF DEATH.

2129 100-02

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 522 Scott ST. WARD)

2-FULL NAME Bettie J. Hardin.

(a) RESIDENCE NO. 522 Scott ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 13 dys. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) March 2, 1930.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1,	1,	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Elmer Hardin.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Indiana.

12 MAIDEN NAME OF MOTHER Amelia Hardin.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Annapolis Md.

14 Informant Mrs. Amelia Hardin.
(Address) 522 Scott St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15-1930

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1930, to April 15, 1930, that I last saw her alive on April 14, 1930, and that death occurred, on the date stated above, at 4.35 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 522 Scott St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs and Symptoms

(Signed) Samuel Silverstein, M. D.

, 19 (Address) 27 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Anns cemetery Annapolis

DATE OF BURIAL April 17 1930

20 UNDERTAKER C. Edward Evans

ADDRESS 38 E. Fort Ave.

17 1930 H[illegible] M. D.

Spec.—1-12-23—M&T—500 Blks.

Grace Shipley

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56257

E 56257

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Mc Culloh St., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Shipley

(a) RESIDENCE NO. 1805 Mc Culloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	28?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Reason Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Hannah Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John E Clark 1805 Mc Culloh St

15 Filed 1-7 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr. 5 1930 to Apr. 16 1930

that I last saw h[illegible]live on Apr. 16 1930

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows: Organic Heart Disease

Indefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Garland Mitchell M. D.

Apr 17 1930 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 4/17/1930

20 UNDERTAKER Jos. Geo. H. Holland

ADDRESS Druid Hill Avenue

THIS is very important. See instructions on back.

[illegible]

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56258

CERTIFICATE OF DEATH.

E 56258

REGISTERED NO. 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. West Baltimore General Hospital ST. WARD)

2-FULL NAME Mrs. Louis Swartz

(a) RESIDENCE NO. 511 N. Asquith ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elma Swartz

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	82	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Swartz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bondarin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Paul Swartz

(Address) 2300 Whitelock Ave

15 Filed APR 17 1930, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to April 16, 1930, that I last saw him alive on April 16, 1930 and that death occurred, on the date stated above, at 11:20 p. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S-A Aleni, M. D.

4/17, 1930 (Address) West Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Mondale — DATE OF BURIAL 4/17, 1930

20 UNDERTAKER Jack Lewis — ADDRESS 1434 E Balto

FOR IS VERY Important See instructions

Spec.—8-16-29—L. F. S.—100 Bks.

E 56259 **HEALTH DEPARTMENT—CITY OF BALTIMORE** × 49 ✓ E 56259

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

2—FULL NAME Thomas Murray

(a) RESIDENCE NO. Birmingham Ala ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ala

PARENTS

10 NAME OF FATHER Claude R.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Maud Doolittle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

APR 17 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17-30

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to April 17, 1930, that I last saw h[illegible] alive on April 17, 1930 and that death occurred, on the date stated above, at 2 15 A m.

The CAUSE OF DEATH* was as follows:

(a) Brain Tumor Malignant

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4. 15 30

Was there an autopsy? Yes

What test confirmed diagnosis? Examination

(Signed) [illegible], M. D.

4/17, 1930 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Birmingham, Ala.	April 17, 1930

20 UNDERTAKER ADDRESS

John D. Mitchell & Sons 1900 Eutaw Place

Spec.—1-10-21—M&T—1500 Blks.

E 56260 HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 E 56260

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 21-29 (WARD)

2-FULL NAME Baby Boy Knodt

(a) RESIDENCE NO. 701 W. Hamburg ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) apr 15. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm Knodt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Cath Kasmeier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr William Knodt

(Address) 701 W. Hamburg St

15 Filed APR 7 1930, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-15, 1930, to 4-17, 1930,

that I last saw him alive on 4-17, 1930,

and that death occurred, on the date stated above, at 12 15 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal nephritis toxemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Brewer, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apr 17 1930

20 UNDERTAKER Mr & Mrs J. W. Zenfel & Son

ADDRESS 801 N. Fayette

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56261

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 56261

CERTIFICATE OF DEATH

REGISTERED NO. 12-50

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Mem. Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Bessie Potter

(a) RESIDENCE NO. 3144 Strill Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 31 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Abraham L Potter

11 BIRTHPLACE OF FATHER (city or town) Washington County
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Melessa Jones

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Georgie P. Bowlus

(Address) 3016 Guilford Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1930

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1930, to April 16, 1930, that I last saw h alive on April 16, 1930 and that death occurred, on the date stated above, at 3:50 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical sign

(Signed) Nicholas Sinsheimer, M. D.

4/16, 1930 (Address) Sinai Mem. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Apr. 18 1930

20 UNDERTAKER: J. R. Cook — ADDRESS: 1003 West Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 56262

E 56262

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH German Aged People Home
City of BALTIMORE: (or) N. E. Cor Baltimore & Ruxton Ward)

2-FULL NAME Arnold Henry La Porte

(a) RESIDENCE No. N E Cor Baltimore & Ruxton Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal | 4 Color or Race: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 7. 1853

7 AGE — Years: 87 | Months: 2 | Days: 9 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer) Watchman
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Arnold Laporte

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lindau Germany

12 MAIDEN NAME OF MOTHER Caroline Koch

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant [illegible]
(Address) [illegible]

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/1930.

17 I HEREBY CERTIFY, That I attended deceased from Mar 2 1930 to April 15 1930, that I last saw him alive on April 15 1930, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia, Senile Asthenia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ✓
If not at place of death? ✓
Did an operation precede death? ✓ Date of ✓
Was there an autopsy? Clinical
What test confirmed diagnosis?

(Signed) E Helen Hemmig M. D.
4/16 1930 (Address) 4000 Hallins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Spicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Apr 17 1930

20 UNDERTAKER Howard Cook ADDRESS 1003 N Bond St.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56263 ✓ 49 E 56263

CERTIFICATE OF DEATH.

E 56263

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 132 Augusta Ave ST. 20-11 (WARD)

2-FULL NAME Mary Ellen Doyle

(a) RESIDENCE NO. 132 Augusta ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Doyle Sr

6 DATE OF BIRTH (month, day, and year) May 27 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) New Brunswick Canada

PARENTS

10 NAME OF FATHER Patrick Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Norman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Newfoundland

14 Informant (Address) Mrs Alice Lucas 132 Augusta Ave

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16-1930

17 I HEREBY CERTIFY, That I attended deceased from April 1 1930 to April 16 1930, that I last saw h[illegible] alive on April 15 1930, and that death occurred, on the date stated above, at 2 10P m.

The CAUSE OF DEATH* was as follows:

Cancer Bladder

(duration) 1 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Extension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Objective Symptoms

(Signed) Henry J. Stahn M. D.

4/17 1930 (Address) 414 Fredk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Apr 19 1930

20 UNDERTAKER Wm J. Pickwood Sons — ADDRESS Northern

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56264

REGISTERED NO. E 56264

1—PLACE OF DEATH
CITY OF BALTIMORE. (No. 5730 Pennington Ave. 25 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Bell

(a) RESIDENCE NO. 5730 Pennington Ave. 25 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 9 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: George E. Bell

6 DATE OF BIRTH (month, day, and year): June 19, 1874

7 AGE: Years 55 | Months 9 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS
10 NAME OF FATHER: Isaac E. Stewart
11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md.
12 MAIDEN NAME OF MOTHER: Margaret Shepherd
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Geo. E. Bell
(Address) 5730 Pennington Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to April 14, 1930,
that I last saw h[illegible] alive on April 14, 1930
and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Bright Hemiplegia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) Wm. D. Levin, M. D.
April 16, 1930 (Address) 4815 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. — DATE OF BURIAL: April 18 1930
20 UNDERTAKER: Wm. H. Tuckwell Son — ADDRESS: Lonaconing Md

Spmc—1-30—M. & T.—250 Blks.

E 56265 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56265

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 16-2 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Reamer

(a) RESIDENCE NO. 308 S. Highland Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) March 25, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	56	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Reamer

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Laura ?

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Records of Balto. City Hospitals
(Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-30

17 I HEREBY CERTIFY, That I attended deceased from 2-25-30, 19..., to 4-15-30, 19...,

that I last saw him alive on 4-15-30, 19...,

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Hypocardiac, Chronic Acute

(duration) over 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of -

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Autopsy

(Signed) Harris M. McLean, M. D.

4-17, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL April 19, 1930

20 UNDERTAKER George W. Girsler

ADDRESS 1737 E. Eager St.

APR 17 1930 H. HAMPSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56266

CERTIFICATE OF DEATH

188-103

E 66266

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Mud Hook St. 17-24 Ward)

2-FULL NAME William Spencer

(a) RESIDENCE NO. 1011 Argyle St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (Write the word)
M	Col	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 8 - 1923

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	7	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): School boy
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Walter Spencer

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Rosa Bergen

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant (Address) Walter Spencer 1011 Argyle Ave

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Wagon in which he was riding collided with rear wheel of automobile running very much (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured Skull (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Brady & Myrtle

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Turner M. D.

4/16 1930 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	4-17 1930
20 UNDERTAKER Dan Korn	ADDRESS Balt.

important. See instructions on back of certificate.

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56267

CERTIFICATE OF DEATH Ligons 29 ✓ E 56267

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. (Ward) 16-22

2-FULL NAME William Ligons.

(a) RESIDENCE NO. 805 N. Luzerne St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race Col

5 Single, Married, Widowed or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B. Ligons

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE Years 30 Months Days IF LESS than 1 day ....hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Alfred Ligons

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Emma Andrews

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant (Address) Mrs. Mattie Hudson 1640 W. Saratoga

15 Filed ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus
Accidental
(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Run Nail in foot (duration) yrs. mos.

18 Where was disease contracted if not at place of death? Place of Employment

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

Signed April 14 1930 (Address) Coroner M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 4-17 1930

20 UNDERTAKER Dan'l Easton

ADDRESS 916 Gay

important. See instructions on back of certificate.

Spec. 1-30—M. & T.—250 Blks.

E 56268

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56268

101-64

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balt. City Hosp. ST. 7-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Patrick

(a) RESIDENCE NO. 513 N. Montford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jos. Patrick

6 DATE OF BIRTH (month, day, and year) June 7-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Huffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Sanford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed ... 19... C. THOMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-30

17 I HEREBY CERTIFY, That I attended deceased from 4-4, 1930, to 4-10, 1930, that I last saw h e alive on 4-10, 1930, and that death occurred, on the date stated above, at 8:00 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia left chest

Empyema left chest

(duration) ... yrs. ... mos 21 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia right lung (duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 4-5-30

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Lella Lumpkin, M. D.

4-6 1930 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 6 1930
20 UNDERTAKER	ADDRESS
Wm. G. Miller & Son	2334 Jefferson St

Spec.—8-16-29—L. F. S.—100 Bks.

Time of burial extended to 4-21-30. J. Frederick Stumpf, Asst. Com. of Health

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56269 | 129 | E 56269

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Phila. Rd near Bowleys Ln 26-38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert A. Lepper

(a) RESIDENCE NO. Phila. Rd. near Bowleys Lane ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 22, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Poultry Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Lepper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant August Regner

(Address) Phila Rd. near Bowleys Lane

15 Filed 4/17 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1930

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1930, to April 16 1930, that I last saw him alive on April 15, 1930 and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Chronic Orbular Valvular Disease (Aortic Insufficiency)

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John A. Fisk M. D.

4/17 1930 (Address) 936 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem.

20 UNDERTAKER Mrs. E. Millett Son

DATE OF BURIAL April 21 1930

ADDRESS 2334 Jefferson St.

4-17-1930 Par

Spec.—1-12-23—M&T—500 Blks.

E 56270 HEALTH DEPARTMENT—CITY OF BALTIMORE E/56270

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 Pentman St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Bell

(a) RESIDENCE NO. 533 Pentman ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eddie Bell

6 DATE OF BIRTH (month, day, and year): June 5 1858

7 AGE: Years 71 Months 10 Days 11 If LESS than 1 day, hrs or min. 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Susan Harmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Norah Bell (Address) 832 Eaudubon St

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/16 1930

17 I HEREBY CERTIFY, That I attended deceased from 2/19 1930 to 4/16 1930, that I last saw h[illegible] alive on 4/15 1930 and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

a Colitis 1

chr. nephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Ben Slutter M. D.

19 30 (Address) 213 E Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: April 18 1930

20 UNDERTAKER: J L Brown's Son

ADDRESS: 108 N. Mond

Spec.—1-12-23—M&T—500 Blks.

E 56271 HEALTH DEPARTMENT—CITY OF BALTIMORE 37-98 56271

CERTIFICATE OF DEATH. 21-24 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1101 Russell ST. WARD)

2-FULL NAME Susie Parker

(a) RESIDENCE NO. 1101 Russell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Parker.

6 DATE OF BIRTH (month, day, and year)	Years	Months	Days	If LESS than 1 day, hrs or min
7 AGE	28	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Va.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Peck Ramsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Edith Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lewis Parker, Jr. (Address) 1101 Russell St

Filed APR 17 1930 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1930

17 I HEREBY CERTIFY, That I attended deceased from March 6, 1930, to April 10, 1930, that I last saw her alive on April 12, 1930, and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Acute Nullerary Tuberculosis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Signatures

What test confirmed diagnosis? —

(Signed) Raymond V. Adams, M. D.

(Address) 1703 Baltimore Key Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Yorktown Va

DATE OF BURIAL April 18 1930

20 UNDERTAKER H. C. Brown's Son

ADDRESS Yorktown Va

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56272

CERTIFICATE OF DEATH

101-001 E 56272

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 822 Longan St., 15-21 Ward)

2-FULL NAME Jannetta Savage

(a) RESIDENCE NO. 1872 Lorman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): June 8- 1929

7 AGE: Years 0 | Months 10 | Days 28 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Paul Savage

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Annie Miles

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Paul Savage
(Address) 1872 Lorman

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Coroner (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of ....

Was there an autopsy? No

What was confirmed diagnosis? Pneumonia

(Signed) [illegible] Roberts M. D.

(Address) Lorman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon — DATE OF BURIAL: Sept 18, 1930

28 UNDERTAKER: Mrs. R. I. Elliott — ADDRESS 1725 Baltimore

important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56273 ✓ E 56273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56273 8-1390

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. President Hospital ST., 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eliza Humphries

(a) RESIDENCE NO. 1821 - Chatsham ST. / WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) D C

PARENTS

10 NAME OF FATHER Sam Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) D C

12 MAIDEN NAME OF MOTHER Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edna Jones (Address) 805 N. Stricker St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-30

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1930 to April 15, 1930 that I last saw h— alive on April 15, 1930 at 5:35 P m. and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Mitral " "

Cardiac Decompensation

(duration) about 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Carroll M. St Clair M. D.

, 19 (Address) President Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary cem

DATE OF BURIAL April 17, 1930

20 UNDERTAKER Wm. R. Edmondson

ADDRESS 1710 Madison Ave

Important. Give information called for on this certificate as accurately as possible. Use ink. Write plainly. Do not abbreviate.

APR 17 1930. HARRISON [illegible] M. D.

RFH

Spec.—2-29-28—L. F. S.—500 Blks.

E 56274

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E 56274

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Barnes ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Lipscomb

(a) RESIDENCE NO. 1709 Barnes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Married

3a If married, widowed, or divorced, HUSBAND of (or) WIFE of James Lipscomb.

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Frank Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Cyrus Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lennie Lipscomb

(Address) 1709 Barnes St.

15 1930 C. HUDSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/30

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 1930, to 4/16, 1930,

that I last saw her alive on 4/15, 1930,

and that death occurred, on the date stated above, at 3:50 A. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Lobar Pneumonia (Primary)

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) James R. Blake, M. D.

, 19 (Address) 924 Fagnant St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL April 19, 1930

20 UNDERTAKER Mrs. C. L. Elliott

ADDRESS 17-5 Eutaw

Important. See instructions on back of this sheet.

Cor.—10-10-29—A Co.—100 Bks.

E 56275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56275

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St. 7-13 Ward)

2-FULL NAME Preston J. Witter, Jr.

(a) RESIDENCE NO. Marley Park, Glenburnie, Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28/30

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		2	20 19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Preston J. Witter, Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Katherine M. Horstman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant (Address) Preston J. Witter, Sr. Marley Park, Glenburnie, Md

15 Filed APR 17 1930, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumoncic Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes at Sinai Hospital

What test confirmed diagnosis?

(Signed) [signature], M. D.

4/17/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md Oak Lawn Cem.

DATE OF BURIAL April 19 1930

20 UNDERTAKER Geo. E. Wells & Son

ADDRESS 2334 Jefferson St

Fill in STRONG ink or carefully typewrite. Erase statements not properly classified. Be sure that it may be properly classified. Erase statements not properly classified. Be sure that it may be properly classified. Erase statements not properly classified. Be sure that it may be properly classified

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56276.

E 56276

CERTIFICATE OF DEATH

181-001 56276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2811 Louise Ave St. 27-44 Ward)

2-FULL NAME Albert H. Johnson

(a) RESIDENCE NO. 5908 Benton Heights Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State) Wash. D.C.

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Helen Johnson

6 DATE OF BIRTH (month, day, and year) Feb 20/1895

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	1	24 26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Lieutenant
(b) General nature of industry, business, or establishment in which employed (or employer) U. S. Army.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. W. Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER Ozella Prigg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore. Md.

14 Informant Helen Johnson
(Address) 5908 Benton Heights

15 Filed 4/17 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas Aphixiation from kitchen range. Probably Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Calver, M. D.

(Address) 508 E. North Ave 4/17/30

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Park R. Lehring Cemetery

DATE OF BURIAL Apr 19 1930

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 E. N. Ave

Form should be carefully copied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Rev.—2-20-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56277 X 100-001 E 56277

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hillen Road Lake Montebella Grounds ST. 9-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Thompson Armstrong

(a) RESIDENCE NO. Hillen Road ST., WARD Massachusetts

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

a If married, widowed, ~~or divorced~~ (or) Wife of Thomas Armstrong

6 DATE OF BIRTH (month, day, and year) Jan. 7. 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	93	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Isreal Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Sophia Towne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant James T. Armstrong

(Address) Hillen Road (Lake Montebella)

15 Filed 4-18-1930 C. HAMPSON JONES, M. D. Registrar

R 17 1930

important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 16. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 6th, 1930, to April 16, 1930, that I last saw h-e alive on April 16th, 1930, and that death occurred, on the date stated above, at 9;00 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(duration) 10 days.

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? — Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Robert L. Kirk, M. D.

4/17. 1930 (Address) 3126 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Apl. 18/30

20 UNDERTAKER

ADDRESS 424 N. Broadway

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56278

CERTIFICATE OF DEATH.

74-001

E 56278

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1605 N. Part St 14-28 St. (or Ward)

2-FULL NAME Jacob. Wiest

(a) RESIDENCE No. 1605 N. Part St St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

2 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Wiest

6 DATE OF BIRTH (month, day, and year): Jan 6 th 1852

7 AGE: Years 78 | Months 3 | Days 10 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Jacob Wiest

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country): Germany.

12 MAIDEN NAME OF MOTHER: Barbra Young

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country): Germany.

14 Informant: Catherine Wiest

(Address) 1605 N. Part St. M D

C. HARRISON JONES, M. D.

R 18930 Registrar

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) 19

April 17 th 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1930, to April 17, 1930, that I last saw h[illegible] alive on April 17, 1930, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Respiratory Paralysis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) J. L. Lehner, M. D.

17 Apr. 19 30 (Address) 1301 E Pat St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Date of Burial 4/19 1930

20 UNDERTAKER: Frank A. Fink ADDRESS 915 N. Gay St

Spec.—1-10-21—MAT—1500 Blks.

E 56279 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

69 E 56279

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital, Wilkins Ave & (St.) Caton (Ward) 27

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H. Spencer Jr

(a) RESIDENCE NO. 1941 W. Mulberry St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 ~~Single, Married, Widowed,~~ or Divorced, (write the word): Colored

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 1 30

7 AGE: Years — Months 1 — Days 17 — If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Spencer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del

12 MAIDEN NAME OF MOTHER Hilda Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Wm H. Spencer

(Address) 1941 W. Mulberry St

15 Filed APR 18 1930 C. HAMPSON JONES, M. D. Registrar

By RPK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17-1930

17 I HEREBY CERTIFY, That I attended deceased from 4-2-, 1930, to 4-17-, 1930, that I last saw him alive on 4-17-, 1930, and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows:

Hemophilia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation Circumcision

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/16/30

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Emerson L. Lovell M. D.

4/17, 1930 (Address) 3705 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: 4/19/1930

20 UNDERTAKER: Philip J. Henry — ADDRESS 2016 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56280

E 56280 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1487 N. Linwood Ave. Ward 6-11)

2-FULL NAME Annie C. Johnson

(a) RESIDENCE NO. 1487 N. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Johnson

6 DATE OF BIRTH (month, day, and year) Aug 26 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Mansfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Margaret Short

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. John T. Johnson (Address) 1487 N. Linwood Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16/30

17 I HEREBY CERTIFY, That I attended deceased from Sept. 27, 1930, to April 16, 1930, that I last saw her alive on April 15, 1930, and that death occurred, on the date stated above, at 5 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Hemiplegia (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Buster C. Theime M. D.

, 19 (Address) 1614 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL April 18 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2019 Orleans St

Spec.—1-30—M. & T.—250 Bks.

Helfand

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH.

E 56281

REGISTERED NO. E 56281

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital 13-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Helfand

(a) RESIDENCE NO. 807 Fenwick ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 17. 1930

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work bbl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Judah Helfand

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Ethel Rosenthal

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Step Friend
(Address)

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 17, 1930, that I last saw her alive on April 17, 1930, and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prematurity of the lungs & mother

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Edmund Levin, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Helping Friendship

DATE OF BURIAL 4-18- 19 30

ADDRESS Balto

20 UNDERTAKER Jack Levine, 1439 Balto

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 56282

E 56282

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 University Parkway ST., 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Slingluff Burns

(a) RESIDENCE NO. 806 University Parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 5 mos. 24 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of F. Highlands Burns

6 DATE OF BIRTH (month, day, and year) OCTOBER 24-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of industry, business, or establishment in which employed (or employer) NONE

(c) Name of employer NONE

9 BIRTHPLACE (city or town) BALTIMORE (State or country) MARYLAND

PARENTS

10 NAME OF FATHER FIELDER C. SLINGLUFF

11 BIRTHPLACE OF FATHER (city or town) BALTIMORE (State or country) MARYLAND

12 MAIDEN NAME OF MOTHER MARY JOHNSTON

13 BIRTHPLACE OF MOTHER (city or town) ALEXANDRIA (State or country) VIRGINIA

14 Informant T. Roland SLINGLUFF (Address) RIDERWOOD, MARYLAND

15 Filed APR 6 1936 19... HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from June 9 1929, to April 17th 1930, that I last saw h.r alive on April 16th 1930, and that death occurred, on the date stated above, at 8.20 A m.

The CAUSE OF DEATH* was as follows:

Occlusion of Coronary Artery (2nd occurrence)

(duration) 1 yrs. 10 mos. 8 ds.

CONTRIBUTORY (Secondary) ✓ (duration) ... yrs. ... mos. ... ds.

18 Where was disease contrarted if not at place of death? ✓

Did an operation precede death? No Date of .

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) R. H. Wan Ars, M. D.

417 . 1930 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

20 UNDERTAKER Henry W. Jenkins' Sons Co

DATE OF BURIAL 4-19 1930

ADDRESS Orchard Mc Cullohs

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56283 × 23 E 56283

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) South Baltimore General Hospital (WARD)

2—FULL NAME Phillip W. Ernge

(a) RESIDENCE NO. Glenburnie, 2nd ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Ernst.

6 DATE OF BIRTH (month, day, and year) Feb 4 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Ernst.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Ernst.

(Address) Glenburnie Md

15 Filed APR 18 1930 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16-30

17 I HEREBY CERTIFY, That I attended deceased from 2-27 1930, to 4-16 1930, that I last saw him alive on 4-16 1930 and that death occurred, on the date stated above, at 1085 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Encephalitis Lethargica

(duration) yrs. mos. Chronic

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph H. Kaufmann M. D.

(Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem — DATE OF BURIAL 4/19 1930

20 UNDERTAKER J. Few McCully — ADDRESS 130 E. Front

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56284

E 56284

CERTIFICATE OF DEATH.

57

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 W. Lafayette Ave. ST., 11-3rd Ward)

2-FULL NAME. Elizabeth Baldwin Tinges

(a) RESIDENCE NO. 233 W. Lafayette Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widowed

5a If married, widowed, or divoreed
HUSBAND of
(or) WIFE of Charles Sewall Tinges

6 DATE OF BIRTH (month, day, and year) May 14th 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Robert T. Baldwin

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Ann H. Hart

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Virginia

14 Informant Miss Elizabeth B. Tinges
(Address) 233 W. Lafayette Ave.

15 Filed ..... 19 ..... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 12th, 1930, to April 17th, 1930,

that I last saw h E Y alive on April 17th, 1930,

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

DIABETES MELLITUS

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic NEPHRITIS

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Thomas L. Sheare, M. D.

4/18th, 1930 (Address) 906 N. Charles St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem — DATE OF BURIAL April 19th 1930

20 UNDERTAKER Henry A. Jenkins Sons Co. — ADDRESS McCulloh & Orchard 55

Spec.—1-30—M. & T.—250 Bks.

56285

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56285

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4725 Kenwick Ln ST. Roland Park WARD 25

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Marlow Fitch Cronkhite

(a) RESIDENCE NO. 4725 Kenwick Rd. ST. Roland Park WARD Crystal Lake Ills.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 1/2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (HUSBAND) of (or WIFE of) Charles Hanmer Cronklite

6 DATE OF BIRTH (month, day, and year) Nov. 20. 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (at)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Crystal Lake (State or country) Illinois.

PARENTS

10 NAME OF FATHER John Giddings Fitch

11 BIRTHPLACE OF FATHER (city or town) Pawlet (State or country) Vermont

12 MAIDEN NAME OF MOTHER Caroline Marlow

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Loudoun Co. Virginia

14 Informant Mary F. C. Davis

(Address) 4725 Kenwick Rd Roland Pk. Balto, Md

15 Filed APR 18 1930 HARRISON JONES Registrar

Par .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17/30

17 I HEREBY CERTIFY, That I attended deceased from Apr. 16 1930, to Apr 17 1930, that I last saw h alive on Apr 16 1930, and that death occurred, on the date stated above, at 3-30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? Chas Co Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Raus Price, M. D.

, 19 (Address) Glyndon Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL April 19 1930

20 UNDERTAKER Henry H. Jenkins Sons

ADDRESS McCulloh & Eutaw

Spec.—2-29-28—L. F. S.—500 Blks.

E 56286. ✓

E 56286 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 [redacted]

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 611 McCulloh ST. 14-20 WARD)

2—FULL NAME Samson Jackson

(a) RESIDENCE NO. 1611 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): ~~Married~~ Widowed

6 a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maria

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE: Years 67 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Thomas Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mammie Jackson

(Address): 1611 McCulloh

15 Filed ... 19 ... Registrar

R 18 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16-30

17 I HEREBY CERTIFY, That I attended deceased from April 1. 1930. to April 16. 1930.

that I last saw h[illegible]alive on April 16. 1930

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

Duration

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Surgical

(Signed) Jno. S. Allen M. D.

4/18 1930 (Address) 1508 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fredricksburg, Va

DATE OF BURIAL: 4/19/ 1930

20 UNDERTAKER: Jno. Gs. H. Holland

ADDRESS: 1631 Dumbarton Ave

Spec.—1-30—M. & T.—250 Bks.

E 56287 E 56287 √E 56287

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56287 #6.. E 56287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 726 Aisquith St. (St.) (10-14 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Flanigan

(a) RESIDENCE NO. 726 Aisquith St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22, 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fore Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer M. S. Levy, Hat Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Flanigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Joseph Flanigan (Address) 726 Aisquith St.

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) apr 18-30

17 I HEREBY CERTIFY, That I attended deceased from Jan 8, 1930, to apr 17, 1930, that I last saw h[illegible] alive on apr 17, 1930, and that death occurred, on the date stated above, at 3:30 a. m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1930

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) C. Lu Hamilton, M. D.

4/18, 19 30 (Address) 733 augusta st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: 4/21/ 19 30

20 UNDERTAKER: Harry V. Deitzler, 4101 Edmondson Av

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

E 56288

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56288

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH | Balto City Hospls

CITY OF BALTIMORE: (No. Balto Md ST.) 4-21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Mettam

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Mettam

6 DATE OF BIRTH (month, day, and year) 4-16-55

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Records Balto City Hosp

15 Filed R 1 9 1930 C. HAWLEY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16-30

17 I HEREBY CERTIFY, That I attended deceased from 3-31, 1930, to 4-16, 1930, that I last saw her alive on 4-16-, 1930, and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis-Confusion & Deterioration

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Harry Fedmont, M. D.

(Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mettams Memorial — DATE OF BURIAL 4/19/30

20 UNDERTAKER Harry N. Witzke — ADDRESS 4101 Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56289 ✓ E 56289

E 56289

CERTIFICATE OF DEATH.

47

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Beierlein

(a) RESIDENCE NO. 2009 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Un known yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Beierlein

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Anthony Willay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Alt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

15 Filed R 1-9 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-30

17 I HEREBY CERTIFY, That I attended deceased from 3-3, 1930, to 4-15, 1930, that I last saw h[illegible] alive on 4-15, 1930, and that death occurred, on the date stated above, at 6 50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma right breast

Local metastases

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Lung metastases

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of unknown

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. H. Hampson M. D.

4-16 1930 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL April 14-1930

ADDRESS 501 E 22nd St

20 UNDERTAKER Mary M Weidefeld

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56290

E 56290

REGISTERED NO. 188-103

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. City Hospitals St. No-2 Ward)

2-FULL NAME Thomas Takas

(a) RESIDENCE NO. 3215 E Balto St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8-29-26

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	7	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) &
(State or country) Emma

PARENTS

10 NAME OF FATHER Jas Takas

11 BIRTHPLACE OF FATHER (city or town) &
(State or country) Greece

12 MAIDEN NAME OF MOTHER Bessie Papudes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Greece

14 Informant Jas Takas
(Address) 3215 E Balto Street

15 Filed APR 9 1930 J. HANCOCK JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Ran in front of moving auto motor that struck & ran over him

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull C. C

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fenton St Nr Pratt

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Fraum M. D.

4/8 1930 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 4/9 1930

20 UNDERTAKER Mary Ruth

ADDRESS 1730 Harford Ave

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

E 56291

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56291

CERTIFICATE OF DEATH

188-193

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp St., 9 Ward)

2-FULL NAME Augusto Poliafico

(a) RESIDENCE NO. 3703 E Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/22/24

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	7	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Cosimo Poliafico

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mary Poliafico

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Cosimo Poliafico
(Address) 3703 E Pratt Street

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Run down & over by moving auto

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in front of 2422 N Exeter

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D Braun M. D.

4/18, 1930 (Address) 2939 Mt Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL 4/19 1930

20 UNDERTAKER Mary J Ruth 1730 Harlem Ave

ADDRESS

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56292

CERTIFICATE OF DEATH

38 V

E 56292

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 9401 Sharp ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Cobb

(a) RESIDENCE NO. 9401 Sharp ST., 23 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Cook

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Allen Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hattie Turner

(Address) 229 Middle

15 Filed 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/30

17 I HEREBY CERTIFY, That I attended deceased from 4/7, 1930, to 4/16, 1930, that I last saw h alive on 4/15, 1930 and that death occurred, on the date stated above, at 5.00 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

Arterio (duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

4/17/30 (Address) 1408 D Sharp Apt 2

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 4-19 1930

20 UNDERTAKER John H. Toadvine

ADDRESS 1027 Hound Hill

Spec.—1-10-21—MAT—1500 Blks.

E 56293 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56293
REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 1-2 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Rich

(a) RESIDENCE NO. 1224 McCulloh ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lynchburg Va

PARENTS
10 NAME OF FATHER Virgil Beverly
11 BIRTHPLACE OF FATHER (city or town) (State or country) Va
12 MAIDEN NAME OF MOTHER Rebecca Farrar
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Laura Penfield
(Address) Pimlico Md.

15 Filed APR 17 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16-1930

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1930, to April 16, 1930,
that I last saw her alive on April 14, 1930,
and that death occurred, on the date stated above, at 5:32 A. m.

The CAUSE OF DEATH* was as follows:
Cardiac decompensation
with edema of lungs.

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Anemia or fibrillation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical Con
(Signed) [illegible] M. D.
APR 16, 1930 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Interred	APR 19 1930

20 UNDERTAKER Frank Brealey 758 N. Eden
ADDRESS

APR 19 1930

HAMPSON JONES, M. D.

TION is very important See instructions on back of certificates.

Spec.—1-30—M. & T.—250 Bks.

E 56294 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56294

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2818 Rayner Ave (Ward) 6-68

2-FULL NAME Melinda Irene Warren

(a) RESIDENCE NO. 2818 Rayner Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Aaron Warren

6 DATE OF BIRTH (month, day, and year) June 9, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	81	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co Md

PARENTS

10 NAME OF FATHER Johnnie J. Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Miranda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. L. Warren (Address) 2818 Rayner Ave.

15 Filed , 19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 26th, 1930, to April 17, 1930.

that I last saw h alive on April 16, 1930.

and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Generalized arteriosclerosis.
Myocardial insufficiency.
Chronic nephritis.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. Nickel, M. D.

Apr 18 1930 (Address) 2401 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL		DATE OF BURIAL
Asbury Cem.	Reisterstown	Apr. 19, 1930
20 UNDERTAKER		ADDRESS
Wm Nickel Sons		Norch & Pa

Spec.—1-30—M. & T.—250 Bks.

E 56205 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56205

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2819 Clifton Ave (WARD) 15-64

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Allen Dorney

(a) RESIDENCE NO. 2819 Clifton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Lee Dorney

6 DATE OF BIRTH (month, day, and year) Apr. 26, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Allen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Fannie VanVacter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) W. Va

14 Informant Mrs J. Lee Dorney

(Address) 2819 Clifton Ave

15 Filed , 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from Oct. , 19 29 , to April 16 , 19 30 ,

that I last saw he alive on April 15 , 19 30 ;

and that death occurred, on the date stated above, at 1225 a.m.

The CAUSE OF DEATH* was as follows:

CARCINOMA OF BREAST

(duration) 3+ yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? YES Date of 1927

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1129 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Apr 18 19 30
UNDERTAKER	ADDRESS
Wm Hickner Sons	Norfolk Va

Spec.—1-30—M. & T.—250 Blks

Dr Lehmann 2305 - Eutaw Place

E 56296 HEALTH DEPARTMENT—CITY OF BALTIMORE V. E. 56296

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. 25-32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2807 Maisel St. (Ward)

2-FULL NAME Catherine Williams

(a) RESIDENCE NO. 2807 Maisel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ or) WIFE of Benjamin Williams

6 DATE OF BIRTH (month, day, and year) Aug 23rd 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) St Louis Mo.

PARENTS

10 NAME OF FATHER William Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Horan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Benjamin Williams

(Address) 2807 Maisel St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 14 . 1930 . to April 16 . 1930 . that I last saw h[illegible] alive on April 16 . 1930 . and that death occurred, on the date stated above, at 6 A M m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Frank Lehmann, M. D.

, 19 (Address) 2305 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL 4/19/1930

20 UNDERTAKER Wm Cook 1217 — ADDRESS St Paul St

9 1930 C. HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Blks.

E 56297

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56297

CERTIFICATE OF DEATH.

91-00

1-PLACE OF DEATH St. Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 27-55 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Smith

(a) RESIDENCE NO. 5206 Wilton Heights Ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Minnie Smith

6 DATE OF BIRTH (month, day, and year) Aug 27th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mail Carrier

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer U.S. Govt.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Horace Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Straughn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry G. Smith

(Address) 5206 Wilton Heights Ave

15 Filed APR 10 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18/1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1930, to April 18, 1930, that I last saw him alive on April 15, 1930, and that death occurred, on the date stated above, at 7 30 a m.

The CAUSE OF DEATH* was as follows:

Senile gangrene Left Foot & General Arterio-Sclerosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Leg Amputation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) M Whitridge, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL 4/21/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

HON. is very important! See instructions on back of certificate.

Spec.—1-12-23—MAL—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56298 — CERTIFICATE OF DEATH. — 129 — E 56298

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital ST. WARD) 67447

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Hamilton

(a) RESIDENCE No. 4339 York Road ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Richard Hamilton

6 DATE OF BIRTH (month, day, and year) May 31st 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Geo Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Emily ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: David Hemsworth

(Address) 4339 York Rd

15 Filed OCT 9 1930, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 18 1930

17 I HEREBY CERTIFY, That I attended deceased from 4 - 16 1930, to 4 - 18, 1930, that I last saw her alive on 4 - 18, 1930 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Laboratory

(Signed) A. F. Conrey, M. D.

4 [illegible] 19 [illegible] (Address) Val Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westlook Cemetery — DATE OF BURIAL 4/21/1930

20 UNDERTAKER: Wm Cook — ADDRESS 1217 St Paul St

IMPORTANT: See instructions on

Spec.—2-29-28—L. F. S.—500 Bks.

E 56299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56299

REGISTERED NO. 117

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Woman's Hospital ST., 16-68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Marie Lange

(a) RESIDENCE NO. 1001 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. - mos. - ds. How long in U. S., if foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Edward Lange

6 DATE OF BIRTH (month, day, and year): Dec. 6, 1859

7 AGE — Years: 70 — Months: 4 — Days: 11 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: ? Reis

11 BIRTHPLACE OF FATHER (city or town) (State or country): ✓ Germany

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ✓ Germany

14 Informant: Adelaide Klabin (daughter)

(Address): 4203 Harcourt Rd.

15 Filed APR 19 1930 19 — HILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930 to April 17, 1930

that I last saw her alive on April 17, 1930

and that death occurred, on the date stated above, at 11.50 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) ✓ yrs. ✓ mos. 2 ds.

CONTRIBUTORY (Secondary): Generalized peritonitis (duration) ✓ yrs. ✓ mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of April 14, 1930

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Rudolph J. Schork, M. D.

, 19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~: London Park

DATE OF BURIAL: APR 21 1930

20 UNDERTAKER: Robert S Little

ADDRESS 2700 EDMONDSON AVE.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56300

CERTIFICATE OF DEATH

E 56300

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2185 Eutaw or other St., Ward)

2-FULL NAME Mrs. Vincenza Scalia

(a) RESIDENCE NO. 2185 Eutaw St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 30 mos. ds. How long in U. S., if of foreign birth? yrs. 36 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	W	Married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	65	9	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — Housework
(b) General nature of industry, business, or establishment in which employed (or employer) — Private
(c) Name of employer

9 BIRTHPLACE (city or town) Italy
(State or country)

PARENTS

10 NAME OF FATHER F. Lorusso

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Rohat, Madonna

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant
(Address)

15 Filed ... 19... C. HUMPSON JONES, M. D. Registrar

9 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18-30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Illuminating Gas

one hour (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Wm. J. Reilly Coroner, M. D.

4/19, 1930 (Address) 1139 Druid Hill Ave

*State the disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — New Cathedral — DATE OF BURIAL April 19, 1930

20 UNDERTAKER Frank V. Pistone — ADDRESS 291 S. Bolton

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 56301

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56301

CERTIFICATE OF DEATH.

101-09

REGISTERED NO. 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2796½ Tivoly ST. (WARD)

2-FULL NAME Mrs Margaret Shook

(a) RESIDENCE NO. 2796½ Tivoly ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of Richard A. Shook

6 DATE OF BIRTH (month, day, and year) May 3, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Alexander Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alexander Va.

12 MAIDEN NAME OF MOTHER Catherine West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mr. H. P. Shook

(Address) 2796½ Tivoly Ave.

15 Filed APR 19 1930 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17-1930

17 I HEREBY CERTIFY, That I attended deceased from 4-11-, 1930, to 4-17, 1930, that I last saw h[illegible] alive on 4-17, 1930, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Chas. Wm. Edmunds M. D.

, 19 (Address) 2746 Alameda Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Apr. 19 1930
20 UNDERTAKER Henry Sander & Sons Inc.	ADDRESS Baltimore St. & Broadway

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56302

CERTIFICATE OF DEATH

49E 56302

REGISTERED NO. 2756

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Smith

(a) RESIDENCE NO. 3318 St. Ambrose Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna R. Smith

6 DATE OF BIRTH (month, day, and year) Feb 13-1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Co. Md

PARENTS

10 NAME OF FATHER William Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ann Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Leonard Smith

(Address) 4 Park Heights Ave

15 Filed Apr 9, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17-1930

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1930, to April 17, 1930, that I last saw h[illegible] alive on April 17, 1930 and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas
c metastasis to viscera

(duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Exploratory Date of 4-11-30

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Arthur Raltenni, M. D.

4/17, 1930 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	April 2, 1930
20 UNDERTAKER Horace A. Burgee	ADDRESS 353 Halls Road

Spec.—1-30—M. & T.—250 Blks

E 56303 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56303

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 2904 Clifton Park ST., 8 WARD)

2-FULL NAME Edward Herman Mueller

(a) RESIDENCE NO. 2904 Clifton Park ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 0 mos. 26 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of Lottie Toma Mueller

6 DATE OF BIRTH (month, day, and year) Mar 23 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38	0	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Eastern Contracting Co Baltimore Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Max Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sarah Mphliff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lottie Toma Mueller
(Address) 2904 Clifton Park Ter

15 Filed _____ 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18-1930

17 I HEREBY CERTIFY, That I attended deceased from March 11 1930 to April 18 1930.

that I last saw him alive on April 15 1930.

and that death occurred, on the date stated above, at 3.05 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. _____ mos _____ ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab

(Signed) John F. Finley, M. D.

19 30 (Address) 5522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 4/21/1930

20 UNDERTAKER Wm. Nuber & Son

ADDRESS 2503 Eutaw Pl

C. HAMPSON JONES, M. D.

APR 21 1930

RKW

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56304

CERTIFICATE OF DEATH

129 **E 56304**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 Lancaster ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ANTONIA JAKUBOWSKI,

(a) RESIDENCE NO. 1633 Lancaster ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late John Jakubowski,

6 DATE OF BIRTH (month, day, and year) August 8-1880.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	50	8	9 8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retail

(b) General nature of industry, business, or establishment in which employed (or employer): Meat market,

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland,

PARENTS

10 NAME OF FATHER: Unknown,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland,

12 MAIDEN NAME OF MOTHER: Mary Bartaka.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland,

14 Informant: Miss. Josephine Jakubowski,
(Address): 1633 Lancaster Street

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1930, to April 16, 1930, that I last saw h[illegible] alive on April 14, 1930 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

Duration 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine & Microscopic Test

(Signed) J. M. Dellinott, M. D.

Apr. 18, 1930 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.,	Apr. 22. 1930.
20 UNDERTAKER: J. H. Jr. Sadowski,	ADDRESS: 2215 Pulaski Ave

Spec.—1-30—M. & T.—250 Blks.

E 56305 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56305

CERTIFICATE OF DEATH.

129

27-48

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4806 York Road ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Reverend Joel Brown

(a) RESIDENCE NO. 4806 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Anna Adams

6 DATE OF BIRTH (month, day, and year) Sept. 1, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer) 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Madison Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Fassitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Leulah K. Brown (Address) 4806 York Road

15 Filed APR 19 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan 12, 1930, to April 17, 1930, that I last saw him alive on April 16, 1930, and that death occurred, on the date stated above, at 3.15 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chr Myocarditis
Chr Lat. Nephritis
Old Age

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross findings

(Signed) B. W. Bishop, M. D.

(Address) 521 Sheridan Av

Apl 18. 1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery

DATE OF BURIAL Apr. 19, 1930

20 UNDERTAKER John O. Mitchell & Sons, ADDRESS 1900 Eutaw Pl.

Haldon B. Mitchell

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56306

CERTIFICATE OF DEATH

129 ✓

E 56306

REGISTERED NO.

3-4

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 S. Dallas ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jadwiga Palasik

(a) RESIDENCE NO. 525 S. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Antoni Palasik

6 DATE OF BIRTH (month, day, and year): Oct. 15 1845

7 AGE: Years 84 | Months 6 | Days 2 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: William Radzinski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Agnes Dembicka

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: William Palasik

(Address) 525 S. Dallas St.

15 Filed ... 1930 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 18, 1930, that I last saw her alive on April 17 1930 and that death occurred, on the date stated above, at 12 25 P.

The CAUSE OF DEATH* was as follows: Valvular heart disease and Chronic Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary): acute dilatation of heart

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs and symptoms

(Signed) Samuel Silverstein M. D.

19 (Address) 22 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Cem. DATE OF BURIAL: April 22 1930

20 UNDERTAKER: John McFadden ADDRESS 4014 Chester Ave

Spec.—1-30—M. & T.—250 Bks.

E 56307. HEALTH DEPARTMENT—CITY OF BALTIMORE E 56307.

100-601

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals ST. 21-28 WARD

CITY OF BALTIMORE: (No.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Juliana Thomas

(a) RESIDENCE NO. 1416 Ward ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femele	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER ? Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of
(Address) Balto. City Hospitals.

15 Filed APR 9 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14-30

17 I HEREBY CERTIFY, That I attended deceased from 1-8-28, 19..., to 4-11-30, 19..., that I last saw h... alive on 4-11-30, 19..., and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Fere

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Autopsy

(Signed) Edwin W. McLaurin, M. D.

4-17, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL NS HOPKINS HOSPITAL

DATE OF BURIAL 19

ADDRESS APR 12 1930

20 UNDERTAKER Commissioner Health.

Reg. Wm. E. WOODALL

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 56308

E 56308

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3414 Powhatan Ave. WARD) 15-61

2—FULL NAME William L. Straus

(a) RESIDENCE NO. 3414 Powhatan Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline G. Straus

6 DATE OF BIRTH (month, day, and year) June 16, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Lewis Straus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fanny Marcus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

14 Informant Mr. Philip Straus

(Address) 3414 Powhatan Ave

15 Filed [illegible] 19 [illegible] Registrar

R 13 1930 HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18, 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 10th, 1930, to April 18, 1930, that I last saw h[illegible] alive on April 18, 1930, and that death occurred, on the date stated above, at 11:0 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic cardiac Renal disease (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? no clinical findings

What test confirmed diagnosis?

(Signed) Charles H. Slater M. D.

, 19 (Address) 827 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 4/20/1930.

20 UNDERTAKER David Sondheim

ADDRESS 110-20 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56309

E 56309

CERTIFICATE OF DEATH.

91-602

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2013 Barley St. 12-14 WARD)

2-FULL NAME William David Feldmeyer

(a) RESIDENCE NO. 2013 Barley St ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	widowed

5a If married, widowed, or divorced (or) WIFE of Late Julia A Feldmeyer

6 DATE OF BIRTH (month, day, and year) June 23rd 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	81	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Nettie M. Falle (Address) 2013 Barley St

15 Filed ... 19 ... Registrar

2 0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 14 . 1930 . to April 17 . 1930.

that I last saw h living alive on April 17 . 1930

and that death occurred, on the date stated above, at 3.40 p m

The CAUSE OF DEATH* was as follows:

Gangrene of Both Feet.
Arterio Sclerosis

(duration) yrs. 2 mos 3 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?...

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald D. Tommy, M. D.

4-18. 1930 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Annes. Annapolis. Md

DATE OF BURIAL April 21-1930

20 UNDERTAKER B. L. Hopping, Annapolis, Md.

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Blks.

E 56310 ~~56314~~ HEALTH DEPARTMENT—CITY OF BALTIMORE + 92 ✓ E 56310

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr Albert- Carrico

(a) RESIDENCE NO. 3311-16st n.w. Washington DC WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriet-T

6 DATE OF BIRTH (month, day, and year) Oct-18-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Dr Thomas Carrico

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Priscilla Brent

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

APR 20 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-19-1930

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1930, to April 19, 1930, that I last saw him alive on April 19, 1930 and that death occurred, on the date stated above, at 8.35 P m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(duration) ....yrs. ....mos. 1 ds.

CONTRIBUTORY (Secondary) Dermatomyositis

(duration) 2 yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John Hopkins, M. D.

, 19.... (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington DC.

DATE OF BURIAL 4/20 1930

20 UNDERTAKER G. J. Shrift

ADDRESS 317-9th Cor Wash DC.

Spec.—1-30—M. & T.—250 Bks

E 56311 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56311

CERTIFICATE OF DEATH.

REGISTERED NO. 44

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 4719 Delaware Ave ST. 27-56 WARD)

2-FULL NAME Gustav A Ehrig

(a) RESIDENCE NO. 4719 Delaware Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmine

6 DATE OF BIRTH (month, day, and year) March 19 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gustav Ehrig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Uphaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Griffith

(Address) 4719 Delaware Ave

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1930

17 I HEREBY CERTIFY, That I attended deceased from April 4/30, 19.... to April 17/30 19....,

that I last saw h.... alive on April 17/30, 19....,

and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

Malignancy of Liver (Probably Carcinoma)

unknown (duration) .... yrs. .... mos .... ds.

CONTRIBUTORY (Secondary) .... (duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) .... M. D.

(Address) 508 E. North Ave 4/19/1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 4/24/1930

20 UNDERTAKER W. M. Cook — ADDRESS 1217 St Paul St

C. HAWSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56312

101-001

E 56312

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 8-16 Ward)

2-FULL NAME Edna Alice Walker

(a) RESIDENCE NO. 1821 N. Duncan St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20/1921

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	8	6	28 13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles E. Walker

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Bettie Kriss

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Charles E. Walker
(Address) 1821 N. Duncan St

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chr. Rheumatic Endocarditis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins

What test confirmed diagnosis?

(Signed) E. K. Krauss M. D.

4/19/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	4/21/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56313 188-103 **E 56313**

REGISTERED NO._____
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Union Mem. Hosp. 12-51 St., _____ Ward)

2-FULL NAME Henry N. Bennett

(a) RESIDENCE NO. 2100 N. Charles St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3 3 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Executive 586
(b) General nature of industry, business, or establishment in which employed (or employer) Balto Credit Assn
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER William H Bennett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Wilhelmina Wondelough

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Miss Sadie Burgess
(Address) 1806 Guilford Ave

15 Filed _____ 19__ _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by moving automobile

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Fract Skull - Fract. C Vertebra - Internal (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? in front of 2103 Charles

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Frame

(Signed) _____ M. D.

4/19 1930 (Address) 2929 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	4/21/ 1930
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

important. See instructions on back of certificate.

20 1930

Spec.—1-12-23—M&T—500 Blks.

E 56314 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 56314

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3028 Clifton Park Ter ST. 8-46 WARD)

2-FULL NAME Elizabeth Clapsaw

(a) RESIDENCE NO. 3028 Clifton Park Ter ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) July 8-1843

7 AGE	87 Years	2 Months	11 Days	If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife 037

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Lee A. Bowman. (Address) 3028 Clifton Park Terrace

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1930

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to April 19, 1930, that I last saw her alive on April 18, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ... yrs. 4 mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Young, M. D.

19 (Address) 1003 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	Apr 21 1930

20 UNDERTAKER Wm Cook 1217 St Paul ADDRESS

DR. GEO. C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Blks

E 56315

HEALTH DEPARTMENT—CITY OF BALTIMORE E 56315

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 Nuna ST. 8-12 WARD)

2-FULL NAME Miriam A. Damasie

(a) RESIDENCE NO. 2221 Nuna St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2		26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Carmine Damasie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Elsie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Elsie Damasie
(Address) 2221 Nuna St

15 Filed 4-20 1930 C. HAMPSON JONES, M. D. Registrar RRM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17-30

17 I HEREBY CERTIFY, That I attended deceased from 4-6 1930 to 4-17 1930
that I last saw h alive on 4-16 1930
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows: Lobar Pneumonia

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Uptown
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) [illegible] M. D.
(Address) 1200 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery
DATE OF BURIAL 4/21/1930
UNDERTAKER Wm Cook
ADDRESS 1217 St Paul

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56316 ✓ E 56316

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 630 N. Kenwood Ave ST., 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Emily Krauss

(a) RESIDENCE NO. 630 N Kenwood Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Andrew Krauss

6 DATE OF BIRTH (month, day, and year) December 24-1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71 Years	70	3	26	25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Ferdnand Heintz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Katherine Stelick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Husband

(Address) 630 N. Kenwood Ave

15 Filed APR 26 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19-1930

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1930, to April 19, 1930, that I last saw her alive on April 17, 1930, and that death occurred, on the date stated above, at 9:35 A m.

The CAUSE OF DEATH* was as follows:

Arteria-Sclerosis Cardio-Vascular disease & Chronic Myocarditis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs & Symptom

(Signed) Frank Kaiser Morris, M. D.

, 19 (Address) 1127 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cemetery — DATE OF BURIAL April 22 1930

20 UNDERTAKER August Pasek — ADDRESS 2406 Ashland Ave

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56317

CERTIFICATE OF DEATH

90 E 56317

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1616 Ashburton St. (If Ward)

2-FULL NAME Horace M. Bailer Jr.

(a) RESIDENCE No. 1616 Ashburton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marian A.

6 DATE OF BIRTH (month, day, and year): Aug 25-1826

7 AGE: Years 53 | Months 8 | Days 23 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer): B & O R.R. 806
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carlow Ireland

PARENTS

10 NAME OF FATHER: Chas E Baxter

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Horace M Bailer 1616 Ashburton

15 Filed ..... 19 ..... Registrar

JUN 20 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 17th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Harold Kiggins, M. D.

June 18 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 6/21/30 19

20 UNDERTAKER: Richard W Meyer 1620

ADDRESS: Ashburton St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56318

CERTIFICATE OF DEATH

100-001

E 56318

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General Hospital (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marilyn Tracey

(a) RESIDENCE NO. 3016 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

6a If married, widowed, or divorced RUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4 1930

7 AGE: Years | Months 2½ | Days 13 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Francis McTracey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marie Vogle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Francis McTracey

(Address) 30 K. E Fayette st

15 Filed C. Clayson Jones M D Registrar

0 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19-30

17 I HEREBY CERTIFY, That I attended deceased from 4-19, 1930, to 4-19, 1930, that I last saw h[illegible] alive on 4-19, 1930, and that death occurred, on the date stated above, at 4.40A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph Loughran M. D.

19[illegible] (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: April 21 1930

20 UNDERTAKER: Frank V. Pfeifer

ADDRESS 2116 E. Baltimore

Spec.—1-30—M. & T.—250 Bks.

E 56319

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56319

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1304 E. Lexington St. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elnora Jardon

(a) RESIDENCE No. 1304 E. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Jardon

6 DATE OF BIRTH (month, day, and year) Feb 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairfield Md

PARENTS

10 NAME OF FATHER Samuel Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) James Jardon 1304 E. Lexington St

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17-30

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 17, 1930, that I last saw h[illegible] alive on April 16, 1930, and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lung

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) [illegible], M. D.

4-6, 1930 (Address) 606 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL 4-20-1930

20 UNDERTAKER Byron Wright 218 McCulloh St

ADDRESS

Spec—1-30—M. & T.—250 Blks.

E 56320 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56320

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 20-69 ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mossino

1a) RESIDENCE NO. ? 2611 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Maccino

6 DATE OF BIRTH (month, day, and year) 1853 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Records of BALTIMORE CITY HOSPITALS

15 Filed 2-8-1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19-30

17 I HEREBY CERTIFY, That I attended deceased from 5-4, 1929, to 4-19, 1930,

that I last saw him alive on 4-19, 1930,

and that death occurred, on the date stated above, at 7-20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) yrs. 11 mos. da.

18 Where was disease contracted if not at place of death? Fox

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. Wilson, M. D.

BALTIMORE CITY HOSPITALS

4-19, 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem.

DATE OF BURIAL 4-21-30

20 UNDERTAKER Chas. P. Crawford

ADDRESS 1101 W. Royal Ave

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56321

CERTIFICATE OF DEATH

162 E 56321

REGISTERED NO. 26-34

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3900 E. Philadelphia Rd ST 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Agnes Smith

(a) RESIDENCE NO. 3900 E. Philadelphia Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	~

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) April 4, 1930

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Robinson

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Sadie Robinson (Address) 3900 E. Philadelphia Rd.

Filed APR 20 1930 19 C. HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19/30

17 I HEREBY CERTIFY, That I attended deceased from 4/16, 1930, to 4/19, 1930, that I last saw her alive on 4/19, 1930, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) W. D. Judd, M. D.

4/20 1930 (Address) 3323 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	April 21 1930
20 UNDERTAKER	ADDRESS
Mrs. E. Miller & Son	2334 Jefferson St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56322

CERTIFICATE OF DEATH

165

E 56322

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 418 E. Randall St. St., 24-34 Ward)

2-FULL NAME Annie A. Ward.

(a) RESIDENCE NO. 418 E. Randall St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 0 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John J. Ward.

6 DATE OF BIRTH (month, day, and year) March 31, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	0	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Conrad Swebland.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Hannah Donovan.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant John J Ward, (husband)
(Address) 418 E. Randall St.

15 Filed ..... 19 ..... Registrar

20 1930

important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suicide while mentally deranged.
Paris Green Poisoning.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

4/19, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Apr 21, 1930.
20 UNDERTAKER Margaret D. Flynn	ADDRESS 1422 Light St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 56323

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56323

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1148 W Hamburg ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Maggie Wisenhauer

(a) RESIDENCE NO. 1148 W Hamburg ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced (or) WIFE of: Geo Wisenhauer

7 DATE OF BIRTH (month, day, and year): Nov. 18, 1859

8 AGE: Years 70 Months 6 Days If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 63

(b) General nature of industry, business, or establishment in which employed (or employer): Housework.

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Frederick Wuest

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Seigert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jacob F. Wisenhauer (S

(Address) 1148 W. Hamburg St.

15 Filed 2 0 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1930 to April 18, 1930

that I last saw h W alive on April 18, 1930

and that death occurred, on the date stated above, at 12:40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): C.V.D. disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) F. Otto Walsche M. D.

4/18, 1930 Address) 1126 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: April 2, 1930

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

Spec.—1-10-21—MAT—1500 Blks.

E 56324

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56324

CERTIFICATE OF DEATH.

137

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~Mercy Hosp~~ St. Joseph's Hospital ~~Calvert~~ & Preston ST. WARD)

2-FULL NAME Alice Elliott

(a) RESIDENCE NO. 7517 Ellamont St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE 51 Years 50 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Doud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Thos W. Coffrey

(Address) 7514 Ellamont St

15 Filed APR 20 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1930

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to April 17, 1930,

that I last saw her alive on April 17, 1930,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Bilateral Ovarian cyst. (Rt. cyst twisted)

7

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 4-14-30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 4/21/1930

UNDERTAKER Joseph Straley Sons

ADDRESS Loyola

THIS IS VERY important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56325

E 56325

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Richwood Ave ST. WARD)

2-FULL NAME Mrs. Mary Almas Freeman

(a) RESIDENCE NO. 610 Richwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced (HUSBAND of) or WIFE of Crosley Freeman

6 DATE OF BIRTH (month, day, and year) April 12-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Henry Goodrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Elizabeth Bean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Marys Co Md

14 Informant Mrs Lillian Stevens

(Address) 610 Richwood Ave

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 3rd, 1930, to April 18, 1930.

that I last saw her alive on April 17, 1930.

and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis and Asthma

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald D. Towns, M. D.

(Address) 4142 North Ave 4-19-1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible] Cemetery	Apl 21 19 30
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56326

E 56326

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Hospital for the Insane of Maryland

CITY OF BALTIMORE: (No. Lafayette and John St., 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel Theresa Whitmore

(a) RESIDENCE NO. 431 East Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles Edward Whitmore

6 DATE OF BIRTH (month, day, and year) November 18, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dublin Ireland
(State or country)

PARENTS

10 NAME OF FATHER Thomas Bassa

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Ireland

14 Informant Deborah Charles Whitmore (Wife)
(Address) 431 East Lafayette Avenue

15 Filed 20 1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18/30

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to April 18, 1930, that I last saw h.er alive on April 18, 1930, and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction,
Post Operative

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 14, 1930

Was there an autopsy? Yes I granted

What test confirmed diagnosis? Autopsy

(Signed) Elsie J. Woodyer, M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL April 22 19

20 UNDERTAKER [illegible]

ADDRESS 2016 22nd

Spec.—1-12-23—MAT—500 Blks.

E 56327

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56327

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 713 George St. (WARD) 17-7th

2-FULL NAME Hester Johnson

(a) RESIDENCE NO. 713 George St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Steele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edith Lockey

(Address) 713 George St

15 Filed Apr 20 1930 .19 Registrar R.C.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17th 1930

17 I HEREBY CERTIFY, That I attended deceased from January 18 1930 to April 17 1930, that I last saw her alive on April 16 1930, and that death occurred, on the date stated above, at 10.15a m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Gastric)

(duration) — yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W F Haskell M. D.

4/18 1930 (Address) 601 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Apr. 20 1930

20 UNDERTAKER Mrs. R. C. Elbert

ADDRESS 1705 Ashland Av

APR 20 1930 C. HAMPSON MYERS, M.D.

Spec.—1-30—M. & T.—250 Bks.

E 56328

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56328

CERTIFICATE OF DEATH.

REGISTERED NO. 118

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. 20-69 ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarete Warner

(a) RESIDENCE NO. 2558 W. Balto ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Gustave F. Werner

6 DATE OF BIRTH (month, day, and year) aug 24. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	63	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Albert Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Margaret K. Grace

(Address) 2558 W. Balto. St.

15 Filed ..... 1930 ..... 19 ..... Registrar .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-10, 1930, to 4-19, 1930, that I last saw her alive on 4-19, 1930, and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos 4. 7 ds.

CONTRIBUTORY (Secondary) Toxic sleepy acute nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4-10-30

Did an operation precede death? Yes Date of 4-13-30

Was there an autopsy? No

What test confirmed diagnosis? Chemical toxemia

(Signed) J Leyko, M. D.

4/19, 1930 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Apr 21 1930

ADDRESS

20 UNDERTAKER Chas. L. Mitchell Sons 1900 Eutaw Place

C. HAMPSON JONES

Spec.—8-16-29—L. F. S.—100 Blks.

E 56329

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56329

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas London

(a) RESIDENCE NO. Relay Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Zenia London

6 DATE OF BIRTH (month, day, and year): Sept 15 1888

7 AGE: Years 41 Months 7 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 20

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): U S A

PARENTS

10 NAME OF FATHER: Samuel London

11 BIRTHPLACE OF FATHER (city or town) (State or country): U S A

12 MAIDEN NAME OF MOTHER: Elizabeth Arendell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U S A

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

APR 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19-1930

17 I HEREBY CERTIFY, That I attended deceased from April 17. 1930. to April 19, 1930, that I last saw him alive on April 19, 1930 and that death occurred, on the date stated above, at 4-35 p m.

The CAUSE OF DEATH* was as follows: Brain tumor (Astrocytoma) Surgery

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 19. IV. 30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Ed Campbell M. D.

4/20. 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va

DATE OF BURIAL: Apr 21 1930

20 UNDERTAKER: J. C. Mitchell & Sons.

ADDRESS: 1900 Eutaw Place.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56330

CERTIFICATE OF DEATH.

REGISTERED NO. E 56330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital) (Ward) 25-72

2-FULL NAME Mary Eliz Murphy

(a) RESIDENCE NO. Elkridge Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs mos 3 ds. How long in U. S., if of foreign birth? yrs mos ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (Month) Sept (Day) 18, (Year) 1928

7 AGE: Years 1 Months 5 Days 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robt Murphy

11 BIRTHPLACE OF FATHER (City or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Grace Tracy

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Maryland.

14 Informant (Address): Mrs. Murphy Elkridge Md

15 Date: Oct 1930 (19) C. HAMPSON JONES, M. D. Registrar RFH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-20 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-18 1930, to 4-20 1930, that I last saw him alive on 4-20 1930, and that death occurred, on the date stated above, at 3:2 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? XRay of chest

(Signed) Ernest Spurrier Jr. M. D.

(Address) St agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cem

DATE OF BURIAL: Oct. 22, 30

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

Spec.—1-30—M. & T.—250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56331

CERTIFICATE OF DEATH.

REGISTERED NO. 56331

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2619 Llewelyn St. 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl E. Hahn jr.

(a) RESIDENCE NO. 2619 Llewelyn ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Carl E. Hahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Seitz

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Carl E. Hahn (Address) 2619 Llewelyn Ave.

15 Filed Apr 21 1930 . 19 C. HAWKSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19th 1930

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 19, 1930, that I last saw him alive on April 18, 1930, and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 2 days

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Cephas M. D.

April 19 1930 (Address) 3100 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL April 21 1930

20 UNDERTAKER Frederick Lassahn — ADDRESS Fulleston

Spec.—8-16-29—L. F. S.—100 Bks.

V E56332

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56332

REGISTERED NO. E 56332

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. H-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Markle J Weaver

(a) RESIDENCE NO. Greensboro, Caroline Co. Md ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Atieleen Weaver

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Markle Weaver

(Address) Greensboro Md

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1930.

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to April 20, 1930

that I last saw him alive on April 19, 1930

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Bronchopneumonia

Coronary occlusion

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Ye

What test confirmed diagnosis? Autopsy

(Signed) W. H. Warney M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greensboro Md	April 24 30
20 UNDERTAKER Wm. Cook	ADDRESS 1217 E Fordham

Spec.—8-16-29—L. F. S.—100 Blks.

E 56333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56333

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Stern

(a) RESIDENCE NO. 1734 Palmer Ave ST. New Orleans La WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
F	White	Married

5a If married, widowed, or divorced (or) WIFE of Percival Stern

6 DATE OF BIRTH (month, day, and year) Mch. 29 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Louisiana

PARENTS

10 NAME OF FATHER Theodore Berkeson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Jenny Radetsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 20 1930 HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 '30

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to April 20, 1930, that I last saw h[illegible] alive on April 20, 1930, and that death occurred, on the date stated above, at 3.05 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor, dural endothelioma

Biopsy

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 19 IV 30

Was there an autopsy? Yes

What test confirmed diagnosis? Operation.

(Signed) E. H. Compton M. D.

4/20, 1930 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Orleans, La.

DATE OF BURIAL 4/29 1930

20 UNDERTAKER Harold Landsheim

ADDRESS 18-20 W Mt. Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 56334 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56334

CERTIFICATE OF DEATH

91-002

REGISTERED NO. 16-68

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 N Bentlon ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nathan Elias Young

(a) RESIDENCE NO. 1006 Bentlon St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M.

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Belle Madonta Young

6 DATE OF BIRTH (month, day, and year) 10-5-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Richard Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elizabeth Brewer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Belle M. Young.

(Address) 1006 N. Bentalon St. City.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19-30

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1930, to April 19, 1930, that I last saw h alive on April 19, 1930 and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Dotsenn

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Boyd McCann, M. D.

4/19, 1930 (Address) 400 N Dayton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn, Md. Pine Grove Cemetery.

DATE OF BURIAL Apr. 23 1930.

20 UNDERTAKER C. M. Watts, Winfield Md.

ADDRESS

Spec.—1-30—M. & T.—250 Bks.

56335

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56335

CERTIFICATE OF DEATH.

REGISTERED NO._____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp ST., 15-68 WARD)

2-FULL NAME Esther Hoffman

(a) RESIDENCE NO. 1621 Eutaw St ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1924

7 AGE	Years	Months	Days	If LESS than 1 day, __ hrs. or __ min.
	6	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Jacob Hoffman
11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland
12 MAIDEN NAME OF MOTHER Esther Finfter
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Jacob Hoffman 1621 Eutaw ave

15 Filed JUL 21 1930 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18-30

17 I HEREBY CERTIFY, That I attended deceased from Feb 23 1930 to April 18 1930.
that I last saw her alive on ____ 1 ____ 19____,
and that death occurred, on the date stated above, at 2:30 P m.
The CAUSE OF DEATH* was as follows:
Acute Mastoiditis (R)

(duration) ___ yrs. mos 2 ds.
CONTRIBUTORY (Secondary) Meningitis (Septic)
(duration) ___ yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Feb 25 30
Was there an autopsy? No
What test confirmed diagnosis? Lab Findings Operation

(Signed) _____, M. D.
4/18, 1930 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wartman Circle — DATE OF BURIAL 4/21 1930

20 UNDERTAKER Jack Lewis 1439 E Balto St — ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56336

CERTIFICATE OF DEATH

E 56336

REGISTERED N

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 582 St Mary St., 17-24 Ward)

2-FULL NAME Ida Spencer

(a) RESIDENCE NO. 582 St Mary St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Spencer

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Albert Barnes

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Chas. Spencer
(Address) 178 N. Poppleton

15 Filed ..... 19.. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 17 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or Inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Morbid Conditions) duration Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Regular

What test confirmed diagnosis?

(Signed) H. J. Blanck M. D.

(Address) Hyatt & Barnes

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-24 1930
20 UNDERTAKER Daniel Carter	ADDRESS 516 Eutaw

Important. See instructions on back of certificate.

C. HAMPSON JONES M. D.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56337 45 ✓ E 56337

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1500 Eutaw Place ST. 14-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth C. Codling

(a) RESIDENCE NO. 1500 Eutaw Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Codling

6 DATE OF BIRTH (month, day, and year) April 4/1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo. M. Clay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha M. King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant F. L. Codling

(Address) 1500 Eutaw Place

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18th 1930

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1930, to April 19th, 1930, that I last saw her alive on April 17th 1930 and that death occurred, on the date stated above, at 10:00 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Intestines

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Carcinoma

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Macro-Clinical Diagnosis

(Signed) Chas. E. Whitehead, M. D.

4/8, 1930 (Address) 711 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Cem. Mt. Airy Md	Ap. 21 1930

20 UNDERTAKER Chas. E. Franck ADDRESS 802 Madison Ave

Spec.—1-10-21—M&T—1500 Blks.

56338

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 56338

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 Gilmor ST., 16-22 WARD)

2-FULL NAME Alvin Andrew Blanchard

(a) RESIDENCE NO. 1130 Gilmor ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER James Blanchard

11 BIRTHPLACE OF FATHER (city or town) Balt Md
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Ross

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Virginia Blanchard
(Address) 1130 Gilmor St

15 Filed APR 21 1930 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 20, 1930,

that I last saw him alive on April 15, 1930,

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Fey, M. D.

(Address) 922 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL Apr 21 1930

20 UNDERTAKER Wm. H. Chase & Son

ADDRESS 1405 Mad

Spec.—1-30—M. & T.—250 Blks

E 56339

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56339

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Baltimore, Md. 6-9 7A-001

CITY OF BALTIMORE: (No. 1605 Orleans ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Moody

(a) RESIDENCE No 1605 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred accurate yrs. dys. How long in U. S., if of foreign birth? yrs. mos. dys.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Moody

6 DATE OF BIRTH (month, day, and year) 873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer Herself

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Abram Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot County Md.

12 MAIDEN NAME OF MOTHER Sarah Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Moody (Address) 1605 Orleans St.

15 Filed APR 21 1930 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 18 April 1930

17 I HEREBY CERTIFY, That I attended deceased from 27 Feb. 1930 to 18 Apr. 1930

that I last saw her alive on 17 " 1930

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

~~Uremia~~ days Unconscious.

CONTRIBUTORY (Secondary) Failure (duration) yrs. mos. da.

Chronic Nephritis (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edwin Clifford Kyle, M. D.

19 35 (Address) 6310 N. Carolina St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary cemetery

DATE OF BURIAL April 22, 1930

ADDRESS 1631 Orleans St

UNDERTAKER Edward Bryon

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56340

CERTIFICATE OF DEATH

3/ E 56340

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 47 N. Caroline ST., 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dollie Matthews

(a) RESIDENCE NO. 47 N. Caroline ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6-1905

7 AGE — Years: 24 | Months: 5 | Days: 24 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer N. C.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Thomas Matthews

11 BIRTHPLACE OF FATHER (city or town) N. C.

(State or country)

12 MAIDEN NAME OF MOTHER Daisy Palmer

13 BIRTHPLACE OF MOTHER (city or town) N. C.

(State or country)

14 Informant Thomas Matthews

(Address) 47 N. Caroline St.

15 Filed ..., 19 ... By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18-1930

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 18, 1930.

that I last saw her alive on April 18, 1930

and that death occurred, on the date stated above, at 3:55 a.m.

The CAUSE OF DEATH* was as follows:

Pharyngitis Septicus

(duration) ... yrs. ... mos. 30 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Physical

(Signed) Geo Allen ... M. D.

4-18-1930 (Address) 508 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: April 23 1930

20 UNDERTAKER: Edward Bryan — ADDRESS 1081 Orleans st

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56341

E 56341

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4207 Furley Ave ST. 36-41 WARD) 51

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary J. Erdman

(a) RESIDENCE NO. 4207 Furley Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Erdman

6 DATE OF BIRTH (month, day, and year) May 10 1845

7 AGE Years 84 Months 11 Days 8 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. Ho

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Elsie E. Courtney

(Address) 4207 Furley Ave

15 Filed R 2 1 1930 By H. M. [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 1929, to April 18, 1930, that I last saw her alive on April 18, 1930, and that death occurred, on the date stated above, at 8 55 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur C Manning M. D.

4/18, 1930 (Address) 800 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk

DATE OF BURIAL Apr 21 1930

20 UNDERTAKER Philip Herwig

ADDRESS 2010 Eutaw St

Spec.—1-30—M. & T.—250 Blks.

E 56342

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56342

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 S. Conklin St. 26-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise M. Schubert

(a) RESIDENCE NO. 415 S. Conklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anton J. Schubert

6 DATE OF BIRTH (month, day, and year) Oct 13/1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	5 6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Leonard Pfaff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anton J. Schubert (Address) 415 S. Conklin St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

OCT 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19/30

17 I HEREBY CERTIFY, That I attended deceased from April 13th, 1930, to April 20th, 1930, that I last saw her alive on April 19th, 1930, and that death occurred, on the date stated above, at 12 45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis —
(Bright's Disease)

(duration) ✓ yrs. 3 mos ✓ ds.

CONTRIBUTORY (Secondary) Myocarditis.

(duration) ✓ yrs. 3 mos. ✓ ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. A. Waldron, M. D.

, 19 (Address) 210 East Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	Apr 24 19 30
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Eutaw St.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56343 46 E 56343

E 56343

CERTIFICATE OF DEATH

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE, (NO. Gardner ST. 19-28 WARD)

2-FULL NAME Mrs. Sallie Hopkins

(a) RESIDENCE NO 163 W Mt Henry St ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hopkins

6 DATE OF BIRTH (month, day, and year) June 2 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (City or town) (State or country) A A Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (~~city or~~ town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Md

14 Informant E. M. Forrest.
(Address) 2310 Longwood St. City

15 Filed APR 21 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19-1930

17 I HEREBY CERTIFY, That I attended deceased from 4-9 1930 to 4-19 1930, that I last saw her alive on 4-19 1930, and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ovary

(duration) 4 yrs mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Apr 13-30

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Paul Cohen, M. D.

4/19/30 (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Apr 21 1930

20 UNDERTAKER [illegible]

ADDRESS Notice

FROM A VERY IMPORTANT [illegible] C. HAMILTON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

E 56344

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56344

CERTIFICATE OF DEATH

101-007

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1124 Whitecourt St. 16-22 Ward)

2-FULL NAME Jas Butler

(a) RESIDENCE NO. 1124 Whitecourt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 Color or Race Col | 5 Single, Married, Widowed or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Jan 20th 1930

7 AGE Years | Months 4 | Days 28 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. Butler

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Estella Lowery

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant Estella Butler
(Address) 1124 Whitecourt

15 Filed Jan 21 1930 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 18th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. Quick, M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jan 21 1930

20 UNDERTAKER Virginia A. Linder — ADDRESS 1423 N Caroline

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

E 56345 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 56345

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH Baltimore City Hospitals (T.B. ST. 17-24 WARD) REGISTERED NO.

CITY OF BALTIMORE: (No.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Zorla Petty

(a) RESIDENCE NO. 1129 Myrtle ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Forest Petty

6 DATE OF BIRTH (month, day, and year) Jan. 9, 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 097

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Abel Gullick

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Jane Gullick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records (Address)

15 Filed 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1930, to April 18, 1930, that I last saw h er alive on April 18, 1930, and that death occurred, on the date stated above, at 3.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos Ghumaden M. D.

4-19 1930 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary April 21 1930 DATE OF BURIAL

20 UNDERTAKER Joseph A Sibley 2097 Maunsell ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56346 ✓ 188-103 E 56346

CERTIFICATE OF DEATH.

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Memorial ... (Ward) 12-14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Jeffries

(a) RESIDENCE NO. Irvsoud ... St. ... Ward ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. / ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 - 1853

7 AGE: Years 87 Months 3 Days 16 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work: Automobile Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... (State or country) Va

PARENTS

10 NAME OF FATHER Adrian Jeffries

11 BIRTHPLACE OF FATHER (City or town) ... (State or country) Va

12 MAIDEN NAME OF MOTHER Ellen Bernard

13 BIRTHPLACE OF MOTHER (City or town) ... (State or country)

14 Informant (Address) Mrs Jeffries 23 Cathedral Towson

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto he was driving ran into safety marker then into pole of Railroad Co

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Fract Skull

(Duration) ... yrs. ... mos. ... ds.

(Signed) G. Frank M. D. (Coroner)

4/21 1930 (Address) 3939 m^e Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Fort Hoad Aberdeen Md

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md Date of Burial Apr 22 1930

20 UNDERTAKER H S Marshall ADDRESS 3539 Fait Av

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 56342

56342

CERTIFICATE OF DEATH.

REGISTERED NO. C 135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4016 Penhurst Ave ST. 15-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William A Hoffman

(Residence in Baltimore: No. 4016 Penhurst Ave St.: 75 yrs., 1 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	white	Single

6-DATE OF BIRTH. May 14 1855, 1
(Month) (Day) (Year)

7-AGE. 75 yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Michael Foffman

11-BIRTHPLACE OF FATHER (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER Rosella Bassett

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas M Hoffman

(Address) 4016 Penhurst Ave.

15- Filed 4 21 1930 C. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 19 1930, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 23 1928 191..., to April 19 1930,
that I saw h im alive on April 19 1930,
and that death occurred, on the date stated above, at 10.15PM.

The CAUSE OF DEATH* was as follows:

Infected Kidney

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Toxaemia

(Duration) yrs. mos. 12 ds.

(Signed) Leo L Feltman M. D.

4/21/30 191... (Address) 5400 Walbrook Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet

DATE OF BURIAL, April 22, 1930

20-UNDERTAKER J. Whippert

ADDRESS 1858 Bolton St

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56348

CERTIFICATE OF DEATH

74-001

E 56348

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1103 Darley Avenue ST., 9-18 WARD)

2—FULL NAME Georgianna McNulty

(a) RESIDENCE NO. 1227 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 3 mos. 18 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry W. McNulty

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Barney Bond

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary V. Braden

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Henry W. McNulty

(Address) 1227 E. Lanvale Street

15 Filed APR 21 1930, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/30

17 I HEREBY CERTIFY, That I attended deceased from 4/13, 19 30, to 4/20, 19 30,

that I last saw h[illegible] alive on 4/19, 19 30

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(Duration) Arteriosclerosis yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1227 Lanvale

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. J. Frame, M. D.

4/20, 19 30 (Address) 3939 N. Eldey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: 4/22, 19 30

20 UNDERTAKER: Henry W. Mears and Son — ADDRESS: 325 N. Calvert

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

199 V E 56349

E 56349

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hosp 15-23 Ward)

2-FULL NAME Wm Bowman

(a) RESIDENCE NO. 1329 N Caroy St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Bowman

6 DATE OF BIRTH (month, day, and year) Sept 1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) S. C.
(State or country)

PARENTS

10 NAME OF FATHER Adolphus Boon

11 BIRTHPLACE OF FATHER (city or town) S C
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Emma Bowman
(Address) 634 N Carey St.

15 Filed ..... 19.. Per ..... Registrar

C. HARRISON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Truck in which he was riding struck by B. & O. Train

Hom. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Abscess of Brain sec. to fract skull (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ostend r R Co

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Frame, M. D.

4/21 1930 (Address) 2939 N. Eldon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 4/22 1930

20 UNDERTAKER Samuel Hemdale

ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56350

CERTIFICATE OF DEATH

129 / E 56350

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1357 N. Carey ST. 15-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Rogers Anderson

(a) RESIDENCE NO. 1357 N. Carey ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Elizabeth Anderson

6 DATE OF BIRTH (month, day, and year) March 22

7 AGE: Years | Months: 1 | Days: 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S. Post Office

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER John Andrew Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Esther Pownall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md

14 Informant Mrs. Mary E. Anderson

(Address) 1357 N. Carey St.

15 Filed C. HARRISON JONES, M. D. 19

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17-30

17 I HEREBY CERTIFY, That I attended deceased from Dec. 18, 1929, to April 17, 1930, that I last saw h alive on 4-17, 1930, and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs & Symptoms

(Signed) Wm. H. Campbell M. D.

19 (Address) 924 W. Carollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: April 21 19 30

20 UNDERTAKER: Samuel Kemsley

ADDRESS: 1020 Edmondson Ave

Spec.—1-10-21—M&T—1500 Blks.

Walper

E 56351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 9

E 56351

1-PLACE OF DEATH Md. General Hospital REGISTERED NO.

CITY OF BALTIMORE: (NO. 23-32 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie E. Walper

(a) RESIDENCE NO. 1514 Clarkson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Walper

6 DATE OF BIRTH (month, day, and year) 10-20-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Hospital records

(Address)

15 Filed APR 2 1930 CHAS. G. JONES, M. D. Registrar

By RMP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1930

17

I HEREBY CERTIFY, That I attended deceased from 4/17, 1930, to 4/18, 1930,

that I last saw h[illegible] alive on 4/18, 1930,

and that death occurred, on the date stated above, at 7 55 A. m.

The CAUSE OF DEATH* was as follows:

Chr. glomerular nephritis

& hypertension

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

4/18 (Signed) Thos A. Evans M.D.

1930 (Address) Md. Gen. Hosp.

*Insert (1) Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL April 2 1930

20 UNDERTAKER C. Howard Evans ADDRESS 38 E. Fayette

TION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56352

CERTIFICATE OF DEATH

56352

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (NO.) 519 W Lee St ST. 77-30 WARD)

2-FULL NAME Mary Byrd

(a) RESIDENCE NO. 519 W. Lee St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs 8 mos ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Edward Byrd

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 49 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winnsboro S.C.

PARENTS

10 NAME OF FATHER Saman Nelson

11 BIRTHPLACE OF FATHER (city or town) S.C.

(State or country)

12 MAIDEN NAME OF MOTHER Unknow

13 BIRTHPLACE OF MOTHER (city or town) S.C.

(State or country)

14 Informant Willie Pinkfin

(Address) 619 Lee Street.

15 Filed APR 21 1930

C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3 1930, to 4/19 1930.

that I last saw h alive on 4/19 1930.

and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

1 Day

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Auto cardiac debilitation

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller, M. D.

, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winnsboro S.C

DATE OF BURIAL April 1930

20 UNDERTAKER Joseph A Lively

ADDRESS 409 N Mount St

Spec. 7-17-26 A Co. 200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56353

CERTIFICATE OF DEATH

90 ✓

E 56353

REGISTERED NO.

1-PLACE OF DEATH Aged Womens Home

City of BALTIMORE: (No. 2400 W Lexington St. 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence B Pulfenbaugh

(a) RESIDENCE NO. 1400 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2 1867

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min..
	63	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Westminster Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mrs Martha E Baker

(Address) 1400 W Lexington St

15 Filed APR 21 1930 19 Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927, to April 18, 1930

that I last saw h alive on April 16, 1930

and that death occurred, on the date stated above, at 10:35 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension & Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin B Jewett M. D.

. 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Soicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md — Date of Burial Apr 21 1930

20 UNDERTAKER George J Smith — ADDRESS 33 Hollins

very important. See instructions on back of certificates.

APR 21 1930

Coc.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56354 ✓ E 56354

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp 11-24 Ward)

2-FULL NAME Walter Eggleston

(a) RESIDENCE NO. (5 Lexington Hotel Sparrow Point) Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day and year): 1906

7 AGE — Years: 24 — Months — Days — IF LESS than 1 day hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Bethlehem Steel Co
(c) Name of employer

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Mrs Eggleston
(Address) Sparrow Point Md

15 Filed [illegible], 19__ [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Nov 22 to 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, autopsy or inquiry) thereon and from the evidence obtained by said (inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The Cause of Death was as follows: (Accidental)

2nd & 3rd degree Burns of legs & body,

(duration) 2 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hot Molten Lead fell on legs & body.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Bethlehem Steel Co

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: [illegible] M. D.

(Address) Coroner

•State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rosedale (Co)

DATE OF BURIAL: Nov 24 1930

20 UNDERTAKER: Sam'l H. Kruse Jr

ADDRESS: 1100 Madison

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56355 HEALTH DEPARTMENT—CITY OF BALTIMORE

F-43002
143 E 56355

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Good Shepherd Hospital (Or) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Obelia C. Christian

(a) RESIDENCE NO. 2517 McCulloh ST., — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles

6 DATE OF BIRTH (month, day, and year): ? 1897

7 AGE — Years: 33 — Months: ? — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Chas. C. Christian

(Address): 2517 McCulloh

15 Filed Apr 21, 1930 — [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 18/30

17 I HEREBY CERTIFY That I attended deceased from Apr 15, 1930 to Apr 18, 1930

that I last saw h[illegible] alive on Apr 18, 1930

and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:

Ectopic Pregnancy

(duration) 1 mo. 3 ds.

Exhaustion

CONTRIBUTORY (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted, if not at place of death? 2517 McCulloh

Did an operation precede death? Yes Date of Apr 16-30

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) S. D. Hughes, M. D.

Apr 19 1930 (Address) 1413 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 4/21/1930

20 UNDERTAKER: Mrs Leo H. Rodell

ADDRESS: 601 Druid Hill

Spec.—1-10-21—M&T—1500 Blks.

E 56356

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56356

CERTIFICATE OF DEATH.

X 47 Harriet Lane Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1418 Eutaw Place St. 14-20 WARD)

2-FULL NAME Mrs. Georgia Pinis

(a) RESIDENCE NO. San Francisco California WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs 2 mos — ds How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Pinis (deceased)

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) U-Sa.

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) U-Sa.

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U-Sa.

14 Informant Wm Heise Son (Address) 1418 Eutaw Place-Back md

15 Filed APR 21 1930 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 14 1930, to April 20 1930, that I last saw h-w alive on April 20 1930, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cancer Breast

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Carcinomatosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Dont know.

Did an operation precede death? No Date of —

Was there an autopsy? No. Yes

What test confirmed diagnosis? Gross removal

(Signed) Theodosia Heise Jr., M. D.

4-22 1930 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

San Francisco Cal April 22 1930

20 UNDERTAKER — ADDRESS

Chas. H. Black 742 W. North ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56357

CERTIFICATE OF DEATH

90 ✓ E 56357

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women's Home ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Almira C. Morrison

(a) RESIDENCE NO. Aged Women's Home ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 90 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of James S. Morrison

7 DATE OF BIRTH (month, day, and year) About 1840

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About 90	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of Industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Probably in the State of Vermont

PARENTS

10 NAME OF FATHER: Cannot Ascertain

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) unknown

12 MAIDEN NAME OF MOTHER: Cannot Ascertain

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) unknown

14 Informant: Records of the (Address) Aged Women's Home

15 Filed ..... 19 ..... Registrar

2 P 1930 E. THOMPSON-JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1927 to April 20, 1930.

that I last saw h. ✓ alive on April 17, 1930

and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwin C. Jarrell, M. D.

19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Apl. 22 1930.
20 UNDERTAKER	ADDRESS
Stewart & Mercer Co	Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 122-001 ✓

E 56358

REGISTERED NO. E 56358

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1039 N. Calvert ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Smith

(a) RESIDENCE NO. Westchester Country Club ST., Rye, N.Y. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6 If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Jessie Smith

7 DATE OF BIRTH (month, day, and year) unknown

8 AGE: Years 58; Months; Days; If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Golf Professional

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

10 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

11 NAME OF FATHER: John Smith

12 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

13 MAIDEN NAME OF MOTHER: Jane Maiden

14 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Mrs C. L. Berg

(Address) R.F.D. # 1 Bethel Conn

15 Filed APR 1 1930 19 CLERK JOHNSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1930, to April 20, 1930, that I last saw h[im] alive on April 20, 1930, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of liver (alcoholic)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rye, N.Y.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) John A. Treuchet, M. D.

, 19 (Address) 1039 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New York — DATE OF BURIAL: April 21 1930

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 ✓ E 56359

CERTIFICATE OF DEATH

E 56359

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 19 Broadway Court ST. 7-4 WARD)

2—FULL NAME Mary C. Taylor

(a) RESIDENCE NO. 19 Broadway Court ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Graft. Taylor

7 DATE OF BIRTH (month, day, and year): Oct 12 1860.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69.	5.	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home. Duties

(b) General nature of industry, business, or establishment in which employed (or employer): Wife

(c) Name of employer: In Public

9 BIRTHPLACE (city or town) (State or country): Maryland.

10 NAME OF FATHER: Peter Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Louisa Croll

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Thomas Graft Taylor

(Address) 311 S Bethel St

15 Filed DEC 1 1930 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18/30

17 I HEREBY CERTIFY, That I attended deceased from April . 1930, to April 18 . 1930.

that I last saw h lr alive on April 18 . 1930

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitus Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Probably Cystitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary Test

(Signed) Richard Vorhaus M. D.

, 19 (Address) 1174 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathay Cemetery — DATE OF BURIAL: Dec 31. 1930.

20 UNDERTAKER: Wendel & Leigh — ADDRESS: 300 Edmondson

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56360 — 129 E 56360

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 William St. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Schaefer.

(a) RESIDENCE NO. 908 William St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 10 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Schaefer

6 DATE OF BIRTH (month, day, and year) May 18, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Express-man. 876

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Elizabeth Schaefer.(wife) (Address) 908 William St.

15 Filed 19 Registrar

R 2 1 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1928, to April 18, 1930,

that I last saw him alive on April 18, 1930

and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) 2 yrs. -- mos 16 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M Reinhardt, M. D.

4/18, 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL April 22 1930

20 UNDERTAKER J. Schlosman & Son ADDRESS 1089 Hanover

C. HAMPSON JONES, M. D.

Spec.—1-30—M. & T.—250 Bks.

E 56361 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56361

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH BALTIMORE CITY HOSPITALS ST. 21-21 WARD) REGISTERED NO.

CITY OF BALTIMORE: (No.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George F. Weber

(a) RESIDENCE NO. 1927 Brusoe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND) of (or) WIFE of Georgia Weber

6 DATE OF BIRTH (month, day, and year) April 27, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marble caretaker

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER John Weber

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz. Filling

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Md.

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS, M. D.

15 Filled ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-30

17 I HEREBY CERTIFY, That I attended deceased from 4-3, 1930, to 4-20, 1930, that I last saw him alive on 4-20, 1930, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Delirium Tremens

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren H. Wilson M. D.

4-24 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL April 23 1930

20 UNDERTAKER C. Schlosman & Son ADDRESS 1039 Monroe St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56362

CERTIFICATE OF DEATH

124 E 56362

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2862 Stafford Rd ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William T. Scarbrough

(a) RESIDENCE NO. 2862 Stafford Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bella Scarbrough

6 DATE OF BIRTH (month, day, and year) april 11-1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer

(b) General nature of Industry, business, or establishment in which employed (or employer) commission Merchant

(c) Name of employer Hearn & Hearn Balto. Md.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William T. Scarbrough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Suzanna Pitts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Dorothy Scarbrough.

(Address) 2862 Stafford Rd.

15 Filed ... 19 ... Registrar

R 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) april 19-1930.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1924, to april 19, 1930

that I last saw h alive on april 19, 1930

and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation (Decompensated)

Chronic Tubular Nephritis

(duration) yrs. 3 mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 hour

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Manifest

(Signed) Thos. Ga. Stevens, M. D.

4/20/1930 (Address) 2878 Stafford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 22 1930
20 UNDERTAKER	ADDRESS
Fred A. Wannerson	703 Howard St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56363

CERTIFICATE OF DEATH

57 E 56363

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 S. Linwood Ave ST., 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theodore Buraczynski

(a) RESIDENCE NO. 1111 S. Linwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Buraczynski

7 DATE OF BIRTH (month, day, and year) April 20, 1871

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn. R. R.

9 BIRTHPLACE (city or town) (State or country) Austria Poland

10 NAME OF FATHER Casimir Buraczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Elizabeth Buraczynski

(Address) 1111 S. Linwood Ave

15 Filed 4 21 1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1930

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1930, to April 17, 1930,

that I last saw him alive on April 16, 1930

and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

diabetes Mel—

abt 3 yrs. (duration)

CONTRIBUTORY (Secondary) pyaemia 1 wk (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. F. Wright, M. D.

4/19, 1930 (Address) 1814 E. Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem

DATE OF BURIAL April 22 1930

20 UNDERTAKER Stephen A. Fialkowski INC.

ADDRESS 1000 S. Kenwood Ave

Spec.—2-29-28—L. F. S.—800 Bks.

Macey.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56364

CERTIFICATE OF DEATH

129

E 56364

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5001 Medwood ave ST., 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary H Macey

(a) RESIDENCE NO. 5001 Medwood Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank Macey Sr

7 DATE OF BIRTH (month, day, and year) Jan 3 1866

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) B. T. Co.
(State or country) Md

10 NAME OF FATHER John J Hull

11 BIRTHPLACE OF FATHER (city or town) B. T. Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Julia L. Kinnamon

13 BIRTHPLACE OF MOTHER (city or town) B. T. Co.
(State or country) Md.

PARENTS

14 Informant Frank Macey Jr
(Address) 5001 Medwood ave

15 Filed APR 21 1930 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20-30

17 I HEREBY CERTIFY, That I attended deceased from June 2 1929 to April 20 1930,

that I last saw h alive on April 19 1930

and that death occurred, on the date stated above, at 9 A M m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Chronic Nephritis

Chronic Myocarditis

(duration) 5+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. H. Bishop M. D.

(Address) 5001 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cemetery

DATE OF BURIAL April 22nd 1930

20 UNDERTAKER George S Schilling & Sons

ADDRESS 426 E Monument St

Spec. 130 M. & T.—250 Blks.

E 56365

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56365

CERTIFICATE OF DEATH.

144

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 N. Luzerne ST., 712 WARD)

2-FULL NAME Anna M. Mackey

(a) RESIDENCE NO. 1113 N. Luzerne ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Michael L. Mackey

7 DATE OF BIRTH (month, day, and year) July 29 1901

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Louis A. Haun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Schwartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Michael L. Mackey 1113 N. Luzerne Ave.

15 Filed 2 7 1930 C. HAMILTON JONES, M. D. Registrar RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18th/30

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1930, to April 18, 1930, that I last saw her alive on April 15, 1930, and that death occurred, on the date stated above, at 12 45 m.

The CAUSE OF DEATH* was as follows: Postpartum hemorrhage, the result of a tear in the left side of the cervix uteri, following delivery of a male child. (duration) yrs. mos 18 hours ds.

CONTRIBUTORY (Secondary) Pregnancy (normal) (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? ~~~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. R. Wright, M. D.

7/21, 1930 (Address) 2225 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL April 22nd 30

20 UNDERTAKER Lilly & Zieber Inc.

ADDRESS 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56366

CERTIFICATE OF DEATH.

E 56366

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2539 Ashton ST. WARD 69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George G Clements Jr.

(a) RESIDENCE NO. 2539 Ashton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 20 1930

7 AGE Years Months Days If LESS than 1 day, 6 hrs. or/3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George Clements

11 BIRTHPLACE OF FATHER (City or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Burkett

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Maryland

14 Informant George Clements (Address) 2539 Ashton

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1930

17 I HEREBY CERTIFY, That I attended deceased from . 19 . to . 19 .

that I last saw h alive on . 19 .

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Double

(duration) 1/2 hour yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Jameson M. D.

4/ , 1930 (Address) Aliceanna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL Apr. 22 1930

20 UNDERTAKER Easton Sons ADDRESS Ellicott

C. HAMPSON JONES, M. D.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56367

E 56367

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2539 Ashton St., (Ward)

2-FULL NAME Murl R Clements

(a) RESIDENCE NO. 2539 Ashton St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21 1930

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or 2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER George Clements

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Ella Burket

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant George Clements (Address) 2539 Ashton

15 Filed Apr 21 1930 . 19 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1930

17 I HEREBY CERTIFY, That I attended deceased from . 19 . to . 19 .

that I last saw h alive on . 19 .

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

6 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed C. H. Jones, M. D.

Apr 21, 1930 (Address) Ashton.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Western Cem. DATE OF BURIAL Apr 25, 30

20 UNDERTAKER Easton Sons ADDRESS Ellicott

Spec.—8-16-29—L. F. S.—100 Blks.

E 56368

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56368

CERTIFICATE OF DEATH

1—PLACE OF DEATH U S Marine Hospital #1 REGISTERED NO. 22-30

CITY OF BALTIMORE: (No. Remington Ave & Wyman Park ST. (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fred Lind

(a) RESIDENCE NO. 415 W. Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lind

6 DATE OF BIRTH (month, day, and year) May 16, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Odd Jobs

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer Various

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER William Lind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Bertha Stenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sweden

14 Informant Patients Hospital Record

(Address)

15 Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1930, to April 20, 1930, that I last saw him alive on April 20, 1930 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) J. H. Jones, M. D.

4/20, 1930 (Address) U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
U. S. National Cem	4-22 1930
20 UNDERTAKER	ADDRESS
Robert Brooks & Son	Calhoun Hollins st.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56369

E 56369

CERTIFICATE OF DEATH

91-00

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2714 Hugo Ave. ST., 9-46 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MARIA T. HEINEMAN

(a) RESIDENCE NO. 2714 Hugo Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? 78 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Heineman

DATE OF BIRTH (month, day, and year) March 18, 1840

AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	90	1	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)
(State or country) Germany

10 NAME OF FATHER Christian Yingling

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Maria Kimmerle

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. John Heineman (Husband)
(Address) 2714 Hugo Avenue

15 Filed ___, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10 -, 1930, to April 19 -, 1930, that I last saw h~~er~~ alive on April 19 -, 1930 and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deg. Arterio-Vascular Cystem

(duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Frank C. Hunter, M. D.

, 19 (Address) 125 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL Apr. 22. 1930

20 UNDERTAKER Henry Sandler & Sons. Inc

ADDRESS Baltimore St & Broadway.

Spec.—8-16-29—L. F. S.—100 Bks.

E 36370 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56370

236 E 36370

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Schmidt

(a) RESIDENCE NO. 6305 Beechwood Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 7-1863

7 AGE: Years 67; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Lewis Rush

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Catherine Rhoda

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Friends (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 21 1930 Registrar C. HAMPSON JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20/30

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1930, to April 20, 1930, that I last saw h[illegible] alive on April 20, 1930, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia Bronchopneumonia ?

(duration) yrs. mos. few ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Hedwig Kaercher, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: April 23 19 30

20 UNDERTAKER: Bernard A Fink — ADDRESS: 734 Poplar Grove St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56371

E 56371

CERTIFICATE OF DEATH

1-15 181-081

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 421 E. Biddle St 1-15 Ward)

2-FULL NAME Stephen H. Evans

(a) RESIDENCE NO. 421 E. Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Evans

6 DATE OF BIRTH (month, day, and year) July 6/ 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	57	9	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Bermuda

PARENTS

10 NAME OF FATHER James E. Evans

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bermude

12 MAIDEN NAME OF MOTHER Sarah Guantlet

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bermuda

14 Informant Florence Evans
(Address) 421 E Biddle St

15 Filed ..., 19... ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr. Myocarditis
Contributory- Inhalatio of Illuminating Gas from Smothered gas range- Accidental (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What (esl confirmed diagnosis?

(Signed) [signature], M. D.

4/21/30 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	4/22/1930
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

Important. See instructions on back of certificate.

2 1930

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56372

E 56372

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1528 Poplend St. Curtis Bay, 25-7 Ward) 81-001

2-FULL NAME Charles E. Mitchell.

(a) RESIDENCE NO. 1528 Poplend St. Curtis Bay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Emma Mitchell.

6 DATE OF BIRTH (month, day, and year) September 7, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38	7	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Operator,
(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Industrial
(c) Name of employer Alcohol Co.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wilbur Mitchell.

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Arrildt.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Emma Mitchell, (wife)
(Address) 1528 Poplend St. Curtis Bay.

15 Filed ..... 19 1930 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said decreased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Accidental illuminating gas poisoning.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) Otto H. Feinhardt, M. D.

4/21, 1930 (Address) 101 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 4/22/1930

20 UNDERTAKER C. J. Fanning & Son - 1386. Fayette

ADDRESS

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Blks.

✓ 656373

656373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO. 27-43

1-PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll Phillips

(a) RESIDENCE NO. 6915 Harford Rd. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 16 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tennessee

12 MAIDEN NAME OF MOTHER Emily Enson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm E. Enson

(Address) 1352 W. 41st St

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

1930 Pd. RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/30

17 I HEREBY CERTIFY, That I attended deceased from 3/20/30, 19..., to 4/20/30, 19...,

that I last saw h... alive on 4/20/30, 19...,

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Uremia (duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David Jenner, M. D.

4/20/30 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 4/23/1930

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-10-21—MAT—1500 Blks.

E 56374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56374

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2525 E Biddle ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Frances Blaney

(a) RESIDENCE NO. 32 S. Ensley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: William Thomas Blaney

6 DATE OF BIRTH (month, day, and year): 1848 Feb. 8

7 AGE: Years 82 Months 2 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rocks Harford Co Md

PARENTS

10 NAME OF FATHER: Thomas Boughter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rocks Md

12 MAIDEN NAME OF MOTHER: Mary Tate

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rocks Md

14 Informant (Address): Laura Blaney 32 S Ensley St

15 Filed [illegible] 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 19 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 19, 1930, that I last saw h[illegible] alive on April 18, 1930, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstial Nephritis

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Alfred A Bruchs M. D.

(Address) 2221 E Baltimo

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Harford Co Cem[illegible] D[illegible] 1930 BURIAL ADDRESS

20 UNDERTAKER: Wm Cook 1257 St Paul St

See instructions on back of certificate. TION is very important.

Spec.—8-16-29—L. F. S.—100 Bks.

E 56375

HEALTH DEPARTMENT—CITY OF BALTIMORE

+177 E 56375

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. University Hospital ST. 30 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Leidlich

(a) RESIDENCE NO. Shipley Str. B.C. ST. Co. Md. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse M. Leidlich

6 DATE OF BIRTH (month, day, and year) 3/15/1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	1	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer (stationary)
(b) General nature of industry, business, or establishment in which employed (or employer) 130
(c) Name of employer Barrett Oil Co

9 BIRTHPLACE (city or town) (State or country) Mt. Westminster

PARENTS
10 NAME OF FATHER Peter Leidlich
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Louisa Kress
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Trsor Leidlich
(Address) 1121 N. Fulton Ave

15 Filed 4-21 1930 19 ASKS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-30

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 20, 1930
that I last saw h[illegible] alive on April 20, 1930
and that death occurred, on the date stated above, at 10:30 A.m.

The CAUSE OF DEATH* was as follows:
Secondary anaemia, probably due to benzol poisoning. (duration) yrs. 9 mos. dys.
CONTRIBUTORY (Secondary) Probable central embolism (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis?
(Signed) W. H. Varney M. D.
. 19 (Address) Universt Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery
DATE OF BURIAL 5/23 1930
20 UNDERTAKER Hilbon Cook
ADDRESS 1217 E Lond St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56376

CERTIFICATE OF DEATH

89 E 56376

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1267 William ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George A. Soper

(a) RESIDENCE NO. 1267 William ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia B. Soper

DATE OF BIRTH (month, day, and year) 6/19/1851

AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	78	10	1	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 067

(c) Name of employer White Star S.S. Co

BIRTHPLACE (city or town) (State or country) Va.

10 NAME OF FATHER Wilkerson Soper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Amelia Soper

(Address) 1267 William St

15 Filed ____, 19____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20-1930

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1930, to April 20, 1930,

that I last saw ~~him~~ alive on April 20, 1930

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ___ yrs. 3 mos. ___ ds.

CONTRIBUTORY (Secondary) ___ (duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Wheeler, M. D.

9/21, 1930 (Address) 1279 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/24 1930
20 UNDERTAKER Wm. Cook	ADDRESS
1211 St. Paul St.	

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56377

REGISTERED NO. E 56377

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2825 Rayner St. 16-68 Ward)

2-FULL NAME Mary E. Andrews

(a) RESIDENCE No. 2825 Rayner St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thos M Andrews

6 DATE OF BIRTH (month, day, and year) Oct 16 1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	72	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Jno Taylor

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Florence Taylor
(Address) 2825 Rayner Ave

15 Filed R 2 2 1930 H. C. HAMPSON JONES, M. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20th 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) H. C. Hampson Jones, M. D. Coroner

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	April 22 1930

20 UNDERTAKER Mary A Gauthrop ADDRESS 2839 Rayner Ave

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56378 × 31 ✓ E 56378

CERTIFICATE OF DEATH.

E 56378

REGISTERED NO._____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital 7-13 ST., WARD)

2-FULL NAME Minnie Halsweig

(a) RESIDENCE NO. 322 Mr. Pleasant Ave Stoneleigh Reisterstown, Md - R.F.D. 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE: Years 43; Months —; Days —; If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Solomon Halsweig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Hanah Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Jack Lewis

(Address): 1439 E Baltimore St

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/21/30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 30, 1930, to Apr. 21, 1930, that I last saw her alive on Apr. 21, 1930, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows: Mediastinal Emphysema

(duration) ... yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 11 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) B J Cohen M. D.

4/21 1930 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bet. Field Windsor Mills Road

DATE OF BURIAL: 4/22 1930

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56379

CERTIFICATE OF DEATH

161-001

E 56379

REGISTERED NO.

1—PLACE OF DEATH Woman's Hosp. of

CITY OF BALTIMORE: (No. ST. 28-6 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Premature Conway

(a) RESIDENCE NO. 3510 Talbot Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. ✓ ds. How long in U. S., if foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year) April 16 1930

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Clinton B Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Dorothea Liess

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mother

(Address)

15 Filed APR 22 1930 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1930

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1930, to April 16, 1930, that I last saw h[illegible] alive on April 16, 1930 and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Therapeutic abortion at 5 months

because of maternal syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity.

(duration) yrs. mos. ds.

18 Where was disease contracted ✓ If not at place of death?

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Sam G. Murray Jr. M. D.

4/17, 1930 (Address) 4 ost Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carnegie Institute

DATE OF BURIAL Apr 17 - 30

20 UNDERTAKER Department of Embryology Carnegie Institute

ADDRESS

Spec.—8-16-29—L. F. S.—100 Blks.

Herbert Everett

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 56380

CERTIFICATE OF DEATH

E 56380

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 N. Eden St. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Everett

(a) RESIDENCE NO. 27 N Eden St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced, HUSBAND of (or) WIFE of: Ellen Everett

7 DATE OF BIRTH (month, day, and year): 1900

8 AGE: Years 30; Months; Days; If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

11 NAME OF FATHER: Andrew Everett

12 BIRTHPLACE OF FATHER (city or town) (State or country): N C

13 MAIDEN NAME OF MOTHER: Leola Mayland

14 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: Ellen Everett

(Address) 27 N Eden St

15 Filed Apr 27 1930 C. HAYWARD JONES, M. D. Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20-30

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to April 20, 1930, that I last saw h[illegible] alive on April 20, 1930, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

4-21 1930 (Address) 508 Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery

DATE OF BURIAL: April 24 1930

20 UNDERTAKER: Edward Bryan

ADDRESS 631 orleans st

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 56381

E 56381

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Josephs Hospital S 26-41 (Ward)

2-FULL NAME J. Albert Bauer

(a) RESIDENCE NO. 53 Sippel Avenue, Reapeburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 8th, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	4	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John D. Bauer

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle L. Callender

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant John D. Bauer
(Address) 53 Sippel Ave. Reapeburg, Md.

15 Filed 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 192 30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute General Hemorrhagia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes at St Joseph

What test confirmed diagnosis?

(Signed) [signature] M. D.

4/21/30 (Address) 503 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 22 1930
20 UNDERTAKER	ADDRESS
Frederick Lassahn Sons	Fullerton

important. See instructions on back of certificate.

APR 22 1930

H. HAMILTON JONES, M. D.

(per) 1-30 M. A T.—250 Blks.

E 56382 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56382

CERTIFICATE OF DEATH.

REGISTERED NO. 124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6605 Belair Road ST 26-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey Comeilman

(a) RESIDENCE NO. 6605 Belair Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Yrs. Harrison mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie J. Comeilman

7 DATE OF BIRTH (month, day and year) July 25 1875

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	25	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bar Tender

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Robert Comeilman

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Fitch

13 BIRTHPLACE OF MOTHER (city or town) Balto Co. (State or country) Md.

14 Informant Mrs Bessie Bradley (Address) Mc Cormick Ave & Belair Rd

15 Filed ..... 19 ..... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 - 1930

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 20, 1930, that I last saw him alive on April 20, 1930, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardio Vascular Renal Disease ?

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Joseph Pokorny M. D.

, 19 (Address) 2206 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Council mark Family — DATE OF BURIAL April 23, 1930

20 UNDERTAKER Frederick Lasahn & Sons — ADDRESS Fullerton

REC'D 1930

Rec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56383 | 129 E 56383

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2205 Druid Hill Ave ST. WARD) 21-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William T. Brown

(a) RESIDENCE NO. 2205 Druid Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the Word)
M	Col	M

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Brown

DATE OF BIRTH (month, day, and year) Jan 31-1871

AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	59	2	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Martha Brown (Address) 2205 Druid Hill Ave

15 Filed APR 22 1930 H. J. PARRISH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/30

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1930, to April 20, 1930, that I last saw him alive on April 19, 1930 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) Wm McCard, M. D.

4-21, 1930 (Address) 2029 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	Apr 23 1930
20 UNDERTAKER	ADDRESS
Sam'l W. Chase & Son	1402 Madison

(per) 1-30—M. & T.—250 Blks.

E 56384 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56384

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2507 Woodbrook ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Carrie Agnes Norris

(a) RESIDENCE NO. 2507 Woodbrook ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced ~~HUSBAND~~ of ~~or~~ WIFE of John E. Norris.

6 DATE OF BIRTH (month, day, and year) Jan 22 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	2	30	

8 OCCUPATION OF DECEASED 037

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John C. Kreiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Benedict Kreiner
(Address) 2507 Woodbrook Ave

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mar 18, 1930, to April 21, 1930,

that I last saw her alive on April 21, 1930,

and that death occurred, on the date stated above, at 10:27 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Appendicitis -

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur Monning M. D.

4/22, 1930 (Address) 800 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Cathedral Cemetery	April 24 1930
20 UNDERTAKER	ADDRESS
Josiah Syfer	1600 N. Neill Ave

Cor.—10-10-29—A Co.—100 Bks.

E 56385

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-201

E 56385

CERTIFICATE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 759 Dover St. 21-24 Ward)

2-FULL NAME William Matthews

(a) RESIDENCE NO. 759 Dover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 30 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		3	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER James Matthews

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mr James Matthews
Address 759 Dover St

Filed _____, 19__ RAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Primary Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

4/24. 1930 (Address) 2759 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	April 23 1930
20 UNDERTAKER	ADDRESS
V. K. Brown & Son	Waverly

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

56386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

56386

100-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Wilmer St. ST. 17-24 WARD)

2-FULL NAME Emma Lee Wharton

(a) RESIDENCE NO. 1143 Wilmer St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8- 1928

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
1	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Clifton Wharton

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Clifton Wharton

(Address) 1143 Wilmer St.

15 Filed ..... 19 ..... Registrar

THOMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20/30

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1930, to April 20, 1930, that I last saw h m alive on April 20, 1930 and that death occurred, on the date stated above, at 12-30 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edw. J. Mueller, M. D.

4/22 1930 (Address) 1230 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 4-22 1930

20 UNDERTAKER Samuel Hemsley

ADDRESS 578 N. Bridge

...sec.—1-30—M. & T.—250 Bks.

E 56387

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56387

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 537 Sanford St. (ST.) 14-54 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice V. Holmes

(a) RESIDENCE NO. 537 Sanford St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

6 If married, widowed, or divorced (Husband) WIFE of Arthur Holmes

7 DATE OF BIRTH (month, day, and year) April 3 1870

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	59		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore (State or country) Md

10 NAME OF FATHER Charles Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Lowe

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

PARENTS

14 Informant Sarah C. Bailey

(Address) 2010 Division St.

15 Filed 4 22 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1930

17 I HEREBY CERTIFY, That I attended deceased from 4/10, 1930, to 4/19, 1930, that I last saw her alive on 4/19, 1930, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows

Chr. Nephritis

Cystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. ds.

Autopsy 4/20

Other Dis. 2 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burgh Clarke, M. D.

(Address) 2139 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 4/22 1930

20 UNDERTAKER Samuel E. Frusley

ADDRESS 1118 Bdle

APR 22 1930 HAMPSON JONES, M. D.

Spec. 7-15-29—500 Blks.

E 56388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 56388

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2011 Madison Ave (St.) 4-4-30 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Ann Dorsey

(a) RESIDENCE NO. 2011 Madison Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1840

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	90			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Edward Casuld

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Catherine Nye

13 BIRTHPLACE OF MOTHER (City or town) Md

(State or country)

14 Informant Julia A Dorsey

(Address) 2011 Madison Ave.

15 Filed ____, 19__ ____ Registrar

CS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1930 19

17 I HEREBY CERTIFY, That I attended deceased from January 1. 1930, to April 20 1930.

that I last saw her alive on April 20 1930.

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as (follows:

Mitral Regurgitation

Senile Pneumonia Foot

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Asthma & Edema

(duration) 5 yrs. mos. ds.

18 Where was disease contracted Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Hamilton M. D.

(Address) 3012 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spare.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

Date of Burial 4/22 1930

20 UNDERTAKER Samuel Donnelly

ADDRESS 578 N Eden

very important. See instructions on back of certificates.

R 2 1930 C. HAMPSON JONES M. D.

...e.—8-29-28—L. F. S.—500 Bks.

E 56389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 56389

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Holbrook ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lovie B. Carlin

(a) RESIDENCE NO. 1527 Holbrook ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) April 2 1863

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67		18	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painted

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Carlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Getzendanner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ella M. Carlin

(Address) 1527 Holbrook st

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to April 20, 1930

that I last saw h[illegible] alive on April 17, 1930

and that death occurred, on the date stated above, at 4 30 m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) W W Payne M. D.

4 22 1930 (Address) 17 Park Plaza Ste

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL April 2[illegible] 1930

20 UNDERTAKER William G. Schaffer

ADDRESS 1816 Monument

Spec.—8-16-29—L. F. S.—100 Bks.

E-56390

E 56390 23600 1

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 E-56390

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy Carroll

(a) RESIDENCE NO. 1637 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cato

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 72 or more — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Day Work 10 yrs

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Caleb Carroll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Betsy Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed 4 22 1930, 19 ES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April-18-1930

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1930, to April 18, 1930, that I last saw her alive on April 18, 1930 and that death occurred, on the date stated above, at 11 40 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): ? Cerebral Hemorrhage 6 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum typing

(Signed) Hedwig Koenig, M. D.

4/15, 1930 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ft. Lincoln Cem

DATE OF BURIAL: April 22 1930

20 UNDERTAKER: Wm J. G. Locke

ADDRESS: 1302 Jefferson

Spec.—2-29-28—L. F. S.—500 Bks.

E 56391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 56391

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 Gilmor ST. 16-27 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie Vanegas

(a) RESIDENCE NO. 827 Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

a If married, widowed, or divorced (or) WIFE of Chas Vanegas

6 DATE OF BIRTH (month, day, and year) Feb 18 1890.

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	2	1	

7 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER John Thomas

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Elizabeth Felton (Daughter)

(Address) 945 Somerset St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19 30. to April 19. 1930.

that I last saw h er alive on April 17. 1930

and that death occurred, on the date stated above, at 8 20A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease cnntracted if not at place of death? Unknown

Did an nperation precede death? no Date of

Was there an autnpsy? none

What test confirmed diagnosis? Physical Exam.

(Signed) C R L Young M. D.

4/19. 1930 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem.

DATE OF BURIAL Apr. 22 1930

20 UNDERTAKER Mrs J. G Locks

ADDRESS 1302 Jefferson

APR 21 1930 C. HAMPSON JONES,

Mar E

Spec.—1-30—M. & T.—250 Blks.

E 56392 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56392

CERTIFICATE OF DEATH.

15-62 109-002

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 Dorchester Road ST. WARD)

2-FULL NAME Martha Keller

(a) RESIDENCE NO. 3205 Dorchester Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Keller

7 DATE OF BIRTH (month, day, and year) Feb. 13. 1848

8 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	2	6	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Daniel James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Martha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. James Tarr
(Address) 3205 Dorchester Road

15 Filed APR 22 1930 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 3rd, 1930, to Apr. 14th, 1930, that I last saw her alive on Apr. 14th, 1930, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:
Septic sore throat
followed by Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M Pulaski, M. D.

, 19 (Address) 3044 Monastery Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Presbyterian, Govans — DATE OF BURIAL: Apr. 22 19 30

20 UNDERTAKER: Bula Wredefield — ADDRESS: 914 Gruntline

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56393 — 90 V E 56393

CERTIFICATE OF DEATH

E 56393

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 W. Monument ST. 11-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David H. Moberly

(a) RESIDENCE NO. 103 W. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Moberly

6 DATE OF BIRTH (month, day, and year) Feb 15-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Customs Inspector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S. Government Baltimore

9 BIRTHPLACE (city or town) (State or country) Frederick Md

10 NAME OF FATHER Levi Moberly

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

PARENTS

14 Informant Thomas A Wonder

(Address) 103 W. Monument St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21-1930

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1929, to April 21, 1930

that I last saw him alive on April 21, 1930

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Cerebrovascular

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Stewart McClenny, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL April 23 1930

20 UNDERTAKER Chas. H. Black — ADDRESS 742 W. North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56394

CERTIFICATE OF DEATH

90 E 56394

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 422 N. Castle St. 6-9 Ward)

2-FULL NAME Philip R. Champness

(a) RESIDENCE NO. 422 N. Castle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Imogene Champness

6 DATE OF BIRTH (month, day, and year) July 28/1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	9	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo. W. Champness

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Margaret Zinkan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md.

14 Informant Imogene Champness
(Address) 422 N. Castle St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20/30 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/21/30 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	April 24 30
20 UNDERTAKER Millard Callender	ADDRESS 2209 Aiken St

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. —100 Blks.

235654

E 56395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 56395

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vera Watkins

(a) RESIDENCE NO. 427 N Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: B

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carter

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 24 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: NR.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alaska

PARENTS

10 NAME OF FATHER: James Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alaska

12 MAIDEN NAME OF MOTHER: Mary Claton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alaska

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 22 1930, 19 C. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20-30

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1930, to April 20, 1930, that I last saw her alive on April 20, 1930 and that death occurred, on the date stated above, at 905 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis
Myocardial Insufficiency
Cardiac Failure. Auricular Fibrillation

t (duration) M yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease rnntracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Flechsendinum Coagts

(Signed) Helwig Koenig, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homiridal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: April 23, 1930

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

Nannie McRoy ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 56396

56396

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 522 Bruns St. 17-16 WARD)

2—FULL NAME Nannie McRoy

(a) RESIDENCE NO. 522 Bruns ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

7 DATE OF BIRTH (month, day, and year) Feb 3, 1897

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

10 NAME OF FATHER Jesse Harrisley

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Minnie Davis

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

PARENTS

14 Informant Martha Johnson

(Address) 522 Bruns St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20/1930

17 I HEREBY CERTIFY, That I attended deceased (from Feb 30, 1930, to April 20, 1930, that I last saw h[illegible] alive on April 20, 1930, and that death occurred, on the date stated above, at 6.25 P.M.

The CAUSE OF DEATH* was as follows:

Cancer (Hemorrhage)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertension Cardio Vascular Disease (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL April 23, 1930

ADDRESS 322 N Schroeder St

20 UNDERTAKER Mr Frank R Williams

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56397 — 165 — E 56397

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 914 N. Calvert St. St., 11-15 Ward)

2-FULL NAME John D. Carpenter.

(a) RESIDENCE NO. 914 N. Calvert St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	77	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watch maker.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report, C.D.
(Address)

15 Filed ... 1930 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide.
Cyanide of potassium poisoning.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

4/22, 1930 (Address) 814 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kennett Square PA — DATE OF BURIAL 4-22nd 1930

20 UNDERTAKER Bernard C. Harle 1000 — ADDRESS S Paca St.

Important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

56398

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56398

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 7x12 ST., WARD)

2-FULL NAME Sarah Seaman

(a) RESIDENCE NO. 803 N. Glover ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year) 1841 ?

AGE: Years 89 ? | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Records of B.C.H.

15 Filed DEC 2 1930 Register Harrison Jones M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19-30

17 I HEREBY CERTIFY, That I attended deceased from 7-23-23, 19..., to 4-19-30, 19...,

that I last saw her alive on 4-19-30, 19...,

and that death occurred, on the date stated above, at 3:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Senile Dementia (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Warren M. McShane, M. D.

4-21, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern Hill Cemetery

DATE OF BURIAL April 22 1930

20 UNDERTAKER D. Lilly & Sons Inc

ADDRESS 403 S. Wood St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56399

E 56399

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 535 S. Eutaw ST., 17 WARD)

2-FULL NAME Mary Schaub

(a) RESIDENCE NO. 535 S. Eutaw ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J. Schaub.

6 DATE OF BIRTH (month, day, and year) Oct. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. city.
(State or country)

PARENTS

10 NAME OF FATHER Daniel Kirsch

11 BIRTHPLACE OF FATHER (city or town) N. Y.
(State or country)

12 MAIDEN NAME OF MOTHER Amelia Lowman

13 BIRTHPLACE OF MOTHER (city or town) Balto. city.
(State or country)

14 Informant Andrew J. Schaub (husband)
(Address) 535 S. Eutaw St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1930

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to April 19-1930,

that I last saw h- alive on April 18 - 1930,

and that death occurred, on the date stated above, at 2.35 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) ..... yrs. ..... mos 6 ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? none Date of .....

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Isaac Bressler, M. D.

19 (Address) 125 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cemetery

DATE OF BURIAL April 20 1930

20 UNDERTAKER Lilly & Zuber Inc.

ADDRESS 403 S. Wolfe St

pec.—1-30—M. & T.—250 Bks

E 56400

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56400

CERTIFICATE OF DEATH.

89

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2317 Edmondson Ave WARD) 26-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Elizabeth Hammerbacher

(a) RESIDENCE NO. 2317 Edmondson Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Hammerbacher

7 DATE OF BIRTH (month, day, and year) Aug 1. 1857.

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Ruths

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Nordhoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Martin Hammerbacher

(Address) 2317 Edmondson Ave

15 Filed APR 24 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20/30.

17 I HEREBY CERTIFY, That I attended deceased from April 18 .19 30. to April 20 .19 30.

that I last saw her alive on April 20 .19 30.

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Cardiac Insufficiency

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Mulcahy, M. D.

4/22/30 (Address) 4002 Parkside

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 23, 1930

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son

ADDRESS 801 W. Fayette

Spec.—8-16-29—L. F. S.—100 Bks.

23E 5890 56401 E 56401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Sheppard

(a) RESIDENCE (No. Wilmington Del ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-2-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Del

10 NAME OF FATHER Harold R

11 BIRTHPLACE OF FATHER (city or town) Del (State or country)

12 MAIDEN NAME OF MOTHER Lillian Humphrey

13 BIRTHPLACE OF MOTHER (city or town) Del (State or country)

PARENTS

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 24 1930 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-21-1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 21, 1930, that I last saw him alive on April 21, 1930, and that death occurred, on the date stated above, at 7:20 p m.

The CAUSE OF DEATH* was as follows:

Streptococcus meningitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-15-30

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) J Whitridge Williams, M. D.

(Address) Johns Hopkins Hospital 4/22/1930

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Drawyers Cem Odessa Del DATE OF BURIAL apr 24 1930

20 UNDERTAKER Wm J Tiebout & Sons ADDRESS Newark

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56402

CERTIFICATE OF DEATH.

15-64 129

REGISTERED NO. E 56402

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3821 Forest Park Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Cosby Webster

(a) RESIDENCE NO. 3821 Forest Park Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

6a If married, widowed, or divorced (HUSBAND of (or) WIFE of) David A. C. Webster

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Lewis F. Cosby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jane E. Bickem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Richard P. Goode

(Address) 3821 Forest Park Ave.

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20 1930

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1930, to Apr 20, 1930,

that I last saw her alive on Apr 20, 19....,

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 1 da.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. 10 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/22 1930 (Address) 2934 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Apr. 23 1930

ADDRESS

20 UNDERTAKER John C. Mitchell & Sons, 1900 Eutaw Pl.

Per Mitchell

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56403

CERTIFICATE OF DEATH.

100-001

E 56403

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 76-37 WARD)

2-FULL NAME Richard White

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year)

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-30

17 I HEREBY CERTIFY, That I attended deceased from 9-18, 19 24 to 4-10, 19 30, that I last saw h[illegible] alive on 4-10, 19 30, and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows: Generalized Arteriosclerosis

(duration) Unknown yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. C. Lumpkin, M. D.

4-15 19 30 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Potter's Field DATE OF BURIAL APR 22 1930 19

20 UNDERTAKER Commissioner Health. ADDRESS

By Wm E. Woodall 1631 Orleans St

UNIVERSITY OF MARYLAND

Spec.—1-30—M. & T.—250 Bks.

E 56404

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56404

CERTIFICATE OF DEATH.

REGISTERED NO. 38

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 6-9 STREET WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robinson Lafayette

(a) RESIDENCE NO. 1835 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

6 If married, widowed, or divorced (or) WIFE of Unknown

7 DATE OF BIRTH (month, day, and year) July 10, 1877

8 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	52	9	6	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Anthony Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Louisa ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) Records of Balto. City Hospitals

15 Filed APR 22 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16-30

17 I HEREBY CERTIFY, That I attended deceased from 1-31-30, 19..., to 4-16-30, 19...,

that I last saw h ill alive on 4-16-30, 19...,

and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. 2½ mos. da.

CONTRIBUTORY (Secondary) Infections Intestinal Colitis over 2½ mos. da.

(duration)

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X-ray

(Signed) Warren W. McLean, M. D.

4-21, 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL APR 23 1930 19

20 UNDERTAKER Commissioner Health.

ADDRESS

4361

APR 22 1930 HAMPSON JONES, M. D. Registrar

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56405

CERTIFICATE OF DEATH

57

E 56405

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1213 N. Potomac ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Pauline Gartside

(a) RESIDENCE NO. 1213 N. Potomac ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~ (write the word): Robert A Gartside

6 If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Robert A Gartside

7 DATE OF BIRTH (month, day, and year): Jan 18, 1865

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: Wm J. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Lily Stitcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Roberta Reed

(Address): 1213 N Potomac St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec 18 1929 to 4-20 1930

that I last saw h[er] alive on 4-19 1930

and that death occurred, on the date stated above, at 11 05 A m.

The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? State of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Wood, M. D.

4/22 1930 (Address) 413 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery

DATE OF BURIAL: 4/23 1930

20 UNDERTAKER: John G. Connelly

ADDRESS: Essex

Form 1-50 M. A. T. 250 Blks.

E 56406 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56406

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001

1-PLACE OF DEATH Balto. City Hospitals

CITY OF BALTIMORE: (NO. ST. 4-7-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Woods

(a) RESIDENCE NO. 400 W. Camden ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 53; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Jas. Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Annie Gilhooly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Records of Balto. City Hospitals

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-30

17 I HEREBY CERTIFY, That I attended deceased from 4-7-30, 19..., to 4-15-30, 19..., that I last saw him alive on 4-15-30, 19..., and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Hemorrhage into Cerebrum

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchitis, chronic (duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marvin M. Wilson, M. D.

4-7, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER Comm. Health.

UNIVERSITY OF MARYLAND

Spec.—1-30—M. & T.—250 Blks.

E 56407 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56407

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH Baltimore City Hospitals (WARD) 3-4

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Laws

(a) RESIDENCE NO. 233 S. Dallas ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Laws

7 DATE OF BIRTH (month, day, and year) Unknown

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER Leonard Laws

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant (Address) Records of Balto. City Hosp.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14-30

17 I HEREBY CERTIFY, That I attended deceased from 4-8-30, 19..., to 4-14-30, 19..., that I last saw h im alive on 4-14-30, 19..., and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic adhesive.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Paul Padgett. M. D.

4-15-30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

UNIVERSITY OF MARYLAND

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56409

CERTIFICATE OF DEATH

E 56409

REGISTERED NO. 161-01

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. 24 ST.) (WARD) (1 W. 1 N. No. 1)

2—FULL NAME Baby Cooley

(a) RESIDENCE NO. 202 S. Bethel ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

COLOR OR RACE: White

Single, Married, Widowed, or Divorced, (write the word):

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) April 5 1930

AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER Carl Cooley

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mary Zawinski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant

(Address)

Filed APR 22 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-5, 1930, to 4-5, 1930

that I last saw h[illegible] alive on 4-5, 1930

and that death occurred, on the date stated above, at 3.10 A. m.

The CAUSE OF DEATH* was as follows: Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) C. G. Douglas, M. D.

(Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: APR 22 1930, 19

20 UNDERTAKER

ADDRESS

C. LAMPSON JONES, M. D. Commissioner of Health.
per W. H. WOODALL

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56409

E 56409

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST 2-4 WARD)

REGISTERED NO. 161-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruby Cooke (Twin No. 11)

(a) RESIDENCE NO. 202 N. Caroline St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX | 4 COLOR OR RACE | 5 Single, Married, Widowed, or Divorced, (write the word)

female | White

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) April 5 1926

AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or 30 min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Paul Cooke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1930

17 I HEREBY CERTIFY, That I attended deceased from 4-5, 1930, to 4-5, 1930, that I last saw her alive on 4-5, 1930, and that death occurred, on the date stated above, at 3.50 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Douglas M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JNS HOPKINS HOSPITAL

DATE OF BURIAL: APR 22 1930 19

20 UNDERTAKER

ADDRESS

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 56410

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56410

CERTIFICATE OF DEATH

152

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. Johns Hopkins Hospital ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Brown

(a) RESIDENCE NO. 717 Gilmanton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

If married, widowed, or divorced: HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) April 7th 1930

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Henry Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Gregory

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

Informant

(Address) Johns Hopkins Hospital

Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1930

17

I HEREBY CERTIFY, That I attended deceased from 4-7 . 1930 . to 4-17 . 1930.

that I last saw her alive on 4-17 . 1930

and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

Septicaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Johns Hopkins Hospital APR 22 1930 W. M. E. RUSSELL

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56411

CERTIFICATE OF DEATH

E 56411

1—PLACE OF DEATH
CITY OF BALTIMORE (No.) South Baltimore General Hospital (STREET) (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Betty Lou Bell

(a) RESIDENCE NO. Pasadena, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 16 1929

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	4	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Elvaton Md

10 NAME OF FATHER Henry B Bell

11 BIRTHPLACE OF FATHER (City or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Carrie E Simmons

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Baltimore Md

14 Informant Henry B Bell
(Address) Pasadena md

15 Filed Apr 21, 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-30

17 I HEREBY CERTIFY, That I attended deceased from 4-15, 1930, to 4-20, 1930,
that I last saw h er alive on 4-20, 1930
and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph Loukaitis, M. D.
, 19 (Address) South Baltimore Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	April 23 1930
20 UNDERTAKER	ADDRESS
John H. Denny	715 Light St

Cor.—10-10-29—A Co.—100 Bks.

E 56412

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56412

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 325 S. Monroe St., 19-28 Ward)

2-FULL NAME Chas. F. Sommers

(a) RESIDENCE NO. 325 S. Monroe St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Sommers

6 DATE OF BIRTH (month, day, and year) Apr 10 - 1866

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64		11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Chas F Sommers

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Harry F Sommers
(Address) 2 Willard St

15 Filed C. E. THOMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and that said deceased came to death (autopsy or inquiry) on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F Brooke, M. D.

4/21, 1930 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL 4/23/1930

20 UNDERTAKER Harry H Witzke ADDRESS 4101 Edmondson

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56413

CERTIFICATE OF DEATH

E 56413

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Bata Fen Hos St., 24-33 Ward)

2-FULL NAME Lillian Merson

(a) RESIDENCE NO. Harmans Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6 - 1914

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	15	6	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Claude M. Merson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Lanna Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Claude M Merson
(Address) Harmans Md Co Md.

15 Filed ..... 19 .....

DEC 2 1935 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Struck & knocked down by moving auto while walking along road

(duration) Instantaneous yrs. mos. ds.

CONTRIBUTORY (Secondary) Fract Skull

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Camp. Ft Meade Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) F. Shaw M. D.

4/22 1930 (Address) 29 39th St Elderly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friendship M E Cem a y Co.	4/23/1930
20 UNDERTAKER Harry H Zike	ADDRESS 4401 Edmondson Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56414

+84 E 56414

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 7-9 Ward)

2-FULL NAME Charles D. Sample

(a) RESIDENCE NO. Honaker, Va St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 28/1921

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	8	3	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Luther Sample

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Annie Fisher

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Tenn.

14 Informant Mr. Ahrens (Funeral Dir)
(Address) Broadway & Fulton

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

4 22 1930

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to o/s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tumor of brain- region of cerebellum

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What (est confirmed) diagnosis?

(Signed) J. W. Cullen, M. D.

4/22/30 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Honaker Va	4/22/30
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Bway

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56415

CERTIFICATE OF DEATH

E 56415

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3325 Virginia ave ST. 27-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vincent Grelli

(a) RESIDENCE NO. 3325 Virginia ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. X mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Philomena Grelli

7 DATE OF BIRTH (month, day, and year) Jan 3 1885

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Shoes

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Anthony Grelli

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Chillani

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Philomena Grelli

(Address) 3325 Virginia ave

15 Filed C. HARRISON JONES, M. Registrar

APR 22 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1930, to April 21, 1930, that I last saw him alive on April 21, 1930 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectaris (Viral)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ?

(Signed) Eugene L. Pearre M. D.

April 22, 1930 (Address) 514 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL April 23 1930

20 UNDERTAKER Frank V. Lipitone

ADDRESS 2813 E. Baltimore St

Spec — 1-12-23—MAT—500 Blks

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56416

CERTIFICATE OF DEATH.

129 E 56416

REGISTERED NO.

(If death occurred in a hospital, or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1919 Druid Hill (St.) 4-20 (Ward)

2-FULL NAME Sophia Spence

(a) RESIDENCE NO. 1919 Druid Hill St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arnold Spence

6 DATE OF BIRTH (month, day, and year) Dec 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (City or town) (State or country) Anne Arundel Co. Md

PARENTS

10 NAME OF FATHER Rev. James Evans

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Maud Ortey (Address) 1917 Druid Hill Ave

15 Filed 2 1930 C. HAMPSON JONES, M. D. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1930

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1930, to April 20, 1930, that I last saw h alive on April 20, 1930, and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. J. Shadley M. D.

4/21, 1930 (Address) 1220 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 4-23 1930

20 UNDERTAKER Geo. H. Holland

ADDRESS 1631 Druid Hill Ave

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56417

E 56417

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 616 Georg ST. 17-25 WARD)

2—FULL NAME Minnie A Newman

(a) RESIDENCE NO. 616 Georg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Linwood

6 DATE OF BIRTH (month, day, and year) Aug. 17-1876

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	8	6	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER John W. Regan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Linwood Newman

(Address) 616 George St

Filed APR 21 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 20, 1930, that I last saw h alive on April 20, 1930, at 1 p m. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J E Weber, M. D.

19 (Address) 1019 Georg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion

DATE OF BURIAL 4/22/1930

20 UNDERTAKER Wm. Geo. H. Holland

ADDRESS 1631 Druid Hill

Spec.—8-16-29—L. F. S.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56418 ✓ 146 E 56418

CERTIFICATE OF DEATH

1—PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 14-20 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Mayden

(a) RESIDENCE NO. 524 Robert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Mayden

7 DATE OF BIRTH (month, day, and year) ? 1898

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32			

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Wyatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ginley Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant John C. Mayden

(Address) 524 Robert St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/30

17 I HEREBY CERTIFY, That I attended deceased from 3/29, 1930, to 4/20, 1930.

that I last saw her alive on 4/20, 1930

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Septicemia (Puerperal)
Endocarditis
Nephritis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Abdominal pregnancy

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/14/30

Was there an autopsy? no Cesarean Section

What test confirmed diagnosis? Clinical

(Signed) Bernard Adams, M. D.

19 37 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	4/20/1930

20 UNDERTAKER Wm. Geo. H. Holland ADDRESS 1602 Druid Hill Ave

C. HAMPSON JONES, M. D.

APR 22 1930

Spec.—1-30—M. & T.—250 Blks.

E 56419 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56419

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore City Hospitals ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Raymond Beach

(a) RESIDENCE NO. 1415 Eastern Ave. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Marrie Ellen

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0K0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Richard H. Beach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha E. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Records of Balto. City Hosp.

15 Filed 2-1930, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21-30

17 I HEREBY CERTIFY, That I attended deceased from 4-14-30, 19..., to 4-21-30, 19...,

that I last saw him alive on 4-21-30, 19...,

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Syphilis, tertiary

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & P

(Signed) [illegible] M. D.

(Address) Balto. City Hosp.

4-21 19 30

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hanover

DATE OF BURIAL Apl 24 19 30

20 UNDERTAKER Chenowith Son

ADDRESS 3617 Eastern Ave

Spec—8-16-29—L. F. S.—100 Blks.

E 56420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 56420

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. 13-S WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Williams

(a) RESIDENCE NO. 2914 Kermit Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	w	Married.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Williams

6 DATE OF BIRTH (month, day, and year) Nov 25 1862

7 AGE	Years	Months 4	Days 25	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Daniel V Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Laura Dunn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md.

14 Informant Jane Williams

(Address) 2914 Kermit Road

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M.D.

2 2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20/30

17 I HEREBY CERTIFY, That I attended deceased from 4-19, 1930, to 4-20, 1930, that I last saw him alive on 4-20, 1930 and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

General Arteriosclerosis

(duration) unknown. yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

uremia. (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? clinical.

(Signed) Henry D. Mellvil, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL April 22 19 30

20 UNDERTAKER Shurowetz Son

ADDRESS 3615 Fleetwood Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 56421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74001 E 56421

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3549 Roland Ave ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles R. Shriver.

(a) RESIDENCE NO. 3549 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Edna V. Shriver.

6 DATE OF BIRTH (month, day, and year) Aug 11 1862

7 AGE	Years	Months 7	Days 19	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Martin Shriver

11 BIRTHPLACE OF FATHER (city or town) md (State or country)

12 MAIDEN NAME OF MOTHER Lucinda Hopkins

13 BIRTHPLACE OF MOTHER (city or town) md (State or country)

14 Informant Edna V. Shriver

(Address) 3549 Roland Ave

15 Filed ... 19 ... Registrar

C. HAMPSON JONES, M. D.

4 27 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 18th 1930. to April 20, 1930.

that I last saw him alive on April 20th, 1930

and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension - Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Nature

(Signed) C. H. Jones, M. D.

April 21 1930 (Address) 503 E 33d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetary Balto Co

DATE OF BURIAL April 22 1930

20 UNDERTAKER J. Edmund Dolan

ADDRESS 3650 Eastern Ave

Spec.—1-30—M. & T.—250 Blks

E 56422 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56422

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE; (No.) 2932 Grantley Road ST. (WARD) 61

2-FULL NAME Edward Lanham

(a) RESIDENCE NO. 2932 Grantley Road ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND (or) WIFE of Ella Lanham

6 DATE OF BIRTH (month, day, and year) Aug 29 64

7 AGE: Years 65; Months 7; Days 24; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Self
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Stephen Lanham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary L. Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Edward E Lanham
(Address): Reisterstown Md

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21-1930

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1930, to April 20, 1930, that I last saw him alive on April 20, 1930, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:
Cardiac Decompensation
Pneumonia Edema

(duration) ... yrs. mos 2 da.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) ... yrs. ... mos. 8 da.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? .....

(Signed) Solomon Strayer, M. D.
, 19 (Address) 1514 Eutaw Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lanham Maryland — DATE OF BURIAL 4/24 1930

20 UNDERTAKER: Ursiann Co 6/6 — ADDRESS 1217 St Paul

C. HAMPSON JONES, M. D.

Spec.—8-16-29—L. F. S.—100 Bks. (Thaddeus D. Willoughby)

E 56423

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56423

CERTIFICATE OF DEATH

REGISTERED NO. 20-27

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2010 Penrose ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thaddeus D Willoughby

(a) RESIDENCE NO. 2010 Penrose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write this word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Willoughby

6 DATE OF BIRTH (month, day, and year): July 1 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Fredericksburg Va

PARENTS

10 NAME OF FATHER: Richard Willoughby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredericksburg Va

12 MAIDEN NAME OF MOTHER: Elizabeth Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wilmington Del

14 Informant: Edmund Willoughby

(Address) 2010 Penrose Ave

15 Filed 4-24 1930 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22 1930

17 I HEREBY CERTIFY, That I attended deceased from April 15th 1930, to April 22 1930,

that I last saw him alive on April 21 1930

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinalysis

(Signed) Barry O'McCleary, M. D.

4-24-30 (Address) 4009 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: 4-24-30

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 E Lord St

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56424 ✓ 47 E 56424

E 56424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Balto City Hosp. 8-29 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME Elizabeth Harris.

(a) RESIDENCE NO. 15 S Talbot ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem'l	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Unknown

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country) ~~Unknown~~ Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ~~Unknown~~ Unknown

(State or country) Maryland

14 Informant Hosp. Records.

(Address) Balto City Hosp.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 22. 1930

17 I HEREBY CERTIFY, That I attended deceased from 7-29, 1929, to 4-22, 1930, that I last saw h[illegible] alive on 4-22, 1930, and that death occurred, on the date stated above, at 2 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of rt breast with local metastases

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 8-5-27

Was there an autopsy? No

What test confirmed diagnosis? Histological Exam.

(Signed) Fred M. Dunkerly, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A. County — DATE OF BURIAL 4/24 1930

20 UNDERTAKER [illegible] Pohl — ADDRESS 1217 St Paul St

Spec.—1-30—M. & T.—250 Bks

Dennon 7/8 ½ Pat Ch Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56425

E 56425

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1.-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4157 Eutaw ST., Aug 27-41 WARD)

2.-FULL NAME John Oliver Downey.

(a) RESIDENCE NO. 4157 Eutaw Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	88	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs W. F. Baldwin 4157 Eutaw Ave

15 Filed ..... 19 ..... Registrar

2 2 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to April 21, 1930, that I last saw h alive on April 21, 1930, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Aortic Cardiac Dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Senility. Chronic Endocarditis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F Baldwin M. D.

4/22, 1930 (Address) 718 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 4/24 1930

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

Spec.—1-10-21—MAT—1500 Blks.

F 56426 HEALTH DEPARTMENT—CITY OF BALTIMORE F. 56426

CERTIFICATE OF DEATH.

REGISTERED NO. 162

1-PLACE OF DEATH St Joseph Hospital
CITY OF BALTIMORE: (No.) Caroline & Orleans (Ward) 1648
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Baby Girl Hatton

(a) RESIDENCE NO. 4917 Midwood Ave Ward
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Apr 22nd 1930

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. 50 min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
10 NAME OF FATHER Harold A. Hatton
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Evelyn N. Wilkinson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harold A Hatton
(Address) 4917 Midwood Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22-30

17 I HEREBY CERTIFY, That I attended deceased from 4-22-30 19 to 4-22-30 19
that I last saw h 46 alive on 4-22-30 19
and that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

atelectasis (congenital) (duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Respiratory Paralysis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical Con
(Signed) W. H. Hundley M. D.
, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetary
DATE OF BURIAL 4/23/1930
ADDRESS
20 UNDERTAKER Wm Cook 1217 St Paul St

CAUSE OF DEATH to plain terms, so that a non-professional person may understand it. See instructions on back
TION is very important

C. HAMPSON JONES, M. D.
APR 22 1930

Spec. 1-10-21—M&T—1500 Blks.

E 56427

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56427

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 140 N. Milton Ave. (St.) (6-10 WARD)

2-FULL NAME Mrs. Louise J. Fields

(a) RESIDENCE NO. 140 N. Milton Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jefferson W. Fields

6 DATE OF BIRTH (month, day, and year) 4-23/1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) Homework

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Maryland

PARENTS

10 NAME OF FATHER Richard Strache

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Calvert J. W. Fields

(Address) 140 Walbrook ave

15 Filed 12-2-1930 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21/1930

17

I HEREBY CERTIFY, That I attended deceased from Sept. 10 1928 to April 21 1930.

that I last saw h[illegible] alive on April 20 1930.

and that death occurred, on the date stated above, at 3.15 a m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma of Uterus, with metastasis to Peritoneal Glands (duration) yrs. 19 mos ds.

CONTRIBUTORY (Secondary) Peritonitis due to malignancy (duration) + yrs. + mos. 3 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles E. Clark, M. D.

(Address) April 21/1930 3214 Piedmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Md Cemetery	4/23/1930

20 UNDERTAKER ADDRESS

Wm Cook 1217 St Paul St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56428

CERTIFICATE OF DEATH.

11 E 56428

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 515 W. Bare ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James. H. Jones.

(a) RESIDENCE NO. 515 W. Bare ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Florence Jones

6 DATE OF BIRTH (month, day, and year) 3-6-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or..... min.
	38	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Henry Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Missouri Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Florence Jones

(Address) 515 W. Bare St

15 Filed ..... 19 ..... Registrar

R 2 3 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1930

17 I HEREBY CERTIFY, That I attended deceased from April 17 1930, to April 22 1930, that I last saw him alive on April 22 1930, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (From dyspepsia)

(duration) yrs mos 20 ds

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary Analysis

(Signed) C B Le Compte, M. D.

, 19 (Address) 113 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sarboro N.C.

DATE OF BURIAL April 25 1930

20 UNDERTAKER H. L. Brown's Son

ADDRESS Roxbury

Spec.—8-16-29—L. F. S.—100 Bks.

56429

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 E 56429

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 E. Lombard St. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie Ciekalewska

(a) RESIDENCE NO. 1741 E. Lombard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4-COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch. 23 — 30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ben Ciekalewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Magdalena Gasiorowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant M. Ciekalewska

(Address) 1741 E. Lombard St.

15 Filed APR 23 1930 HAROLD JAMES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22-30

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 22, 1930, that I last saw her alive on April 21, 1930 and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis,

CONTRIBUTORY (Secondary) Myocardial Dump (duration) yrs. mos. 5 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. B. Bronnlaw, M. D.

(Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: April 23, 30

20 UNDERTAKER: S. W. Brazenski

ADDRESS: 1930 Eastern Ave

Spec.—8-16-29—L. F. S.—100 Blks.

2E-326 56430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 47 ✓ E 56430

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 22-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Bacon

(a) RESIDENCE NO. 2316 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 20-187X

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt-Statistics J.H.H.

(b) General nature of industry, business, or establishment in which employed (or employer) Hosp

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10 NAME OF FATHER Larkin Bacon

11 BIRTHPLACE OF FATHER (city or town) Ill. (State or country)

12 MAIDEN NAME OF MOTHER Louisa Johnson

13 BIRTHPLACE OF MOTHER (city or town) Ill (State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 23 1930 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22-30

17 I HEREBY CERTIFY, That I attended deceased from March 26 1930, to April 22 1930, that I last saw her alive on April 22 1930, and that death occurred, on the date stated above, at 12 40 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism. Twenty minutes (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 3-26-30

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) I. R. Trimble, M. D.

4/22, 1930 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Abingdon, Ill.	Apr. 24 1930

20 UNDERTAKER ADDRESS

J. Stewart & Mowen Co. 108 W. North Ave.

Spec.—3-29-28—L. F. S.—500 Blks.

E 56431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 56431

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3028 Darley Av. ST. 13-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Peyton.

(a) RESIDENCE NO. 3028 Darley Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ruth E. Peyton.

6 DATE OF BIRTH (month, day, and year) Nov 17 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired pd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Joseph Peyton

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Mary Pitt.

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant(E. Lloyd Peyton
(Address) 3028 Darley Av

15 Filed ——— 19 ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 19. 1930. to April 21 1930.

That I last saw h[illegible] alive on April 21 1930

and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic Interstitial
Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion
Fever Typhoid
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Physical Examination

What test confirmed diagnosis?

(Signed) H. L. Darley M. D.

19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudoun Co. Va	19
20 UNDERTAKER	ADDRESS
D. Shumate & Son	

Spec.—1-10-21—M&T—1500 Blks

E 56432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E56432

111-002 56432

REGISTERED NO.

1-PLACE OF DEATH: Mt Gen Hospital (St.) 20-69 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No)

2-FULL NAME: Geo Weiss

(a) RESIDENCE NO. 130 S. Frankline Town

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 (Single, Married, Widowed, or Divorced, (write the word)): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Jan 19-1894

7 AGE — Years: 36 — Months: 3 — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md

10 NAME OF FATHER: Louis Weiss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Rosa Seitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

PARENTS

14 Informant (Address): Mrs Geo Weiss

15 Filed APR 23 1930 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4.20.30

17 I HEREBY CERTIFY, That I attended deceased from 3.28 19 30 to 4.20.30 19 30, that I last saw h living on 4.20.30 19, and that death occurred, on the date stated above, at 2.05 a m.

The CAUSE OF DEATH was as follows:

(Primary) Cerebral Hemorrhage (1 day)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? Home 3.28.30

Did an operation precede death? No Date of 4.14.30

Was there an autopsy? No

What test confirmed diagnosis? Clinical

M. D.

(Signed) [illegible]

(Address) [illegible]

*State (1) Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY

DATE OF BURIAL: 4/23/30

20 UNDERTAKER: F.B. WIPPERT

ADDRESS: 1850 W Balto St

THIS is very important. See instructions on back.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

56433

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. E 56433

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Patapsco ST. 23-33 WARD)

2-FULL NAME Georgeanna Ferguson

(a) RESIDENCE NO. 1109 Patapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. - mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: John Ferguson

6 DATE OF BIRTH (month, day, and year): 12/11/1857

7 AGE: Years 72; Months 4; Days 9.; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): John Ferguson 1109 Patapsco St

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

MAR 23 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 20 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 18, 1930, to Apr 20, 1930, that I last saw h[illegible] alive on Apr 19, 1930 and that death occurred, on the date stated above, at 9.00 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Bronchitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Nathanson M. D.

(Address) 16 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: 4/22/30

20 UNDERTAKER: Geo Lemmbach

ADDRESS: 545 N Fayette St

TION is very important. See instructions on

Spec.—1-10-21—MAT—1500 Blks.

E 56434

E 56434 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1711 W Fayette ST. (WARD) 14-27

2-FULL NAME Kate B. Steiner

(a) RESIDENCE NO. 1711 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 9, 1856

7 AGE: Years 74; Months 3; Days 12; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Md

PARENTS

10 NAME OF FATHER: John A Steiner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fredk Md

12 MAIDEN NAME OF MOTHER: Mary A Brunner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Fannie S. Firestone

(Address) 1711 W Fayette St

15 Filed 5-1-30

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1930

17 I HEREBY CERTIFY, That I attended deceased from April 8 1930, to April 21 1930,

(that I last saw her alive on April 21, 1930,

and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): La Grippe

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. K. O'Neill M. D.

4/22, 1930 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet-Cem Fredk. Md — DATE OF BURIAL: April 24 1930

20 UNDERTAKER: John J. Cowan & Son — ADDRESS: 701 Hollins St

TION is very important. See instructions on back of Certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56435 — 90 — E 56435

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Aisquith ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sr. M. Callista Quinn

(a) RESIDENCE NO. Convent of Notre Dame ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9/1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer Sisters of Notre Dame

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER John Quinn

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Curley

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Sister Sisters of Notre Dame
(Address)

15 Filed 2 8 1930, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1930

17 I HEREBY CERTIFY, That I attended deceased from January 31, 1930, to April 2, 1930, that I last saw h.. alive on April 2, 1930 and that death occurred, on the date stated above, at 8.55 A. M. p. m.

The CAUSE OF DEATH* was as follows:
Hypertension Myocarditis
Acute dilatation heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) F. J. Kirby, M. D.

4/22, 1930 (Address) 1106 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Natch Cliff Md.	4/24/30 19
20 UNDERTAKER	ADDRESS
Frank A. Fink	910 N. Gay St.

Spec.—8-16-29—L. F. S.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56436 ✓ 161-00 E 56436

E 56436

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Cumberland ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Johnson.

(a) RESIDENCE NO. 616 Cumberland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-17-30

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
~~1 day.~~	~~0~~	~~0~~	5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Johnson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Goldi Harvey.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant mother Goldie Harvey

(Address) 616 Cumberland St

15 Filed ... 19 ... Registrar

JUN 3 1930 HAMPSON JONES M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22-30

17 I HEREBY CERTIFY, That I attended deceased from 4-17-30, 19..., to 4-22-30, 19..., that I last saw her alive on 4-21-30, 19..., and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Harvey, M. D.

, 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr. 23 1930

20 UNDERTAKER Virginia A Brooks ADDRESS 1463 N Carey

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56437

E 56437
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
(City of Baltimore: (No. 710 Edmondson St. 17-26 Ward)

2-FULL NAME Wm Leonard.

(a) RESIDENCE NO. 710 Edmondson St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced, (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1870

7 AGE: Years 60 | Months | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mary Hackett
(Address) 1628 Madison Ave

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis
(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What (est confirmed disgnosis? Clinical
(Signed) H. Feldman, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cem | DATE OF BURIAL: Nov 22 1930

20 UNDERTAKER: Samuel F. Kennedy 5701 W Belvedere | ADDRESS

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56438

CERTIFICATE OF DEATH

E 56438

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 631 Penna Ave St., 14-20 Ward)

2-FULL NAME Port Marshall

(a) RESIDENCE NO. 631 Penna Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no

6 DATE OF BIRTH (month, day and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shooker 086
(b) General nature of industry, business, or establishment in which employed (or employer) Race track
(c) Name of employer

9 BIRTHPLACE (city or town) Penn
(State or country)

PARENTS

10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Thos Ledge
(Address) 631 Penna Ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

2 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Negative

(Signed) ..... M. D.

(Address) 1 Apr 30 Edgar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Apr 23 1930
20 UNDERTAKER	ADDRESS
Frank J Hendrix	5707 Belair

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56439

CERTIFICATE OF DEATH

101-001

E 56439

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2646 Maryland Ave. ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Hammond Smith

(a) RESIDENCE NO. 2646 Maryland Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred (yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Valentine Smith

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	68	3 4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles L. Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Hardey

13 BIRTHPLACE OF MOTHER (city or town) Howard County (State or country) Maryland

14 Informant Mrs. L. A. Heigel

(Address) 2646 Maryland Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1930, to April 21, 1930

that I last saw her alive on April 21, 1930

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Bolar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Mitchell, M. D.

4/21 1930 (Address) 1279 Williams St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olive Cemetery, Roslyn	Apr. 23 1930
20 UNDERTAKER Dept H (C of C)	ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56440

E 56440

CERTIFICATE OF DEATH

REGISTERED NO. 89 2755

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5301 Beaufort Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christine Daughton

(a) RESIDENCE NO. 5301 Beaufort Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph D. Daughton

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Staunton Virginia

PARENTS

10 NAME OF FATHER Charles A. Euler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Philimina Faulkstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Charles A. Daughton

(Address) 5301 Beaufort Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 21, 1930, that I last saw her alive on April 21, 1930 and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles E. Wells, M. D.

4/23/30 (Address) 5276 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem

20 UNDERTAKER Jos. L. Cook

DATE OF BURIAL Apr. 24 1930

ADDRESS 1003 West Baltimore St.

Spec.—1-30—M. & T.—250 Bks.

E 56441 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56441

46

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2528 N Butts ST. 20-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Elizabeth Mitchell

(a) RESIDENCE NO. 2528 N Butts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	N	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Mitchell

6 DATE OF BIRTH (month, day, and year) May 4 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Boyce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Phoebe Smith

(Address) 2528 N Balto

15 Filed MAR 3 1930, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22-1930

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3, 1929, to April 22, 1930,

that I last saw her alive on April 21, 1930,

and that death occurred, on the date stated above, at 5.00 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus (Body)

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Physical

(Signed) Eliot W. Johnson, M. D.

, 19 (Address) 3326 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 24 1930

20 UNDERTAKER W M Woodson

ADDRESS 2238 N Avenue

Spec.—8-16-29—L. F. S.—100 Bks.

E 56442 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 56442

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 2210 Roslyn Avenue ST. 15-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry C. Grove

(a) RESIDENCE NO. 2210 Roslyn Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 7 mos. 3 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie Francis

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James Grove

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Caroline Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Mamie E. Grove

(Address) 2210 Roslyn Avenue

15 Filed 4 23, 1930 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 22-30

17 I HEREBY CERTIFY, That I attended deceased from Mar. 31- 1930, to Apr-22 1930, that I last saw him alive on Apr-21- 1930, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Signs.

What test confirmed diagnosis?

(Signed) Hasley Cole, M. D.

4,23, 1930 (Address) 2212 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	4/25 1930

20 UNDERTAKER Henry W. Meares & Son ADDRESS 805 N. Calvert

Spec.—1-12-23—M&T—500 Blks.

RUTH BARNARD

E 56443

E 56443 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (a) No. 508 Pierce St. 18 Ward

2-FULL NAME Ruth Bernard

(a) RESIDENCE No. 508 Pierce St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Luke Bernard

6 DATE OF BIRTH (month, day, and year): 4-21-1908

7 AGE: Years 22; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carrituck, N. C.

PARENTS

10 NAME OF FATHER: Myles Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Ella Gregory

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Ella Gregory

(Address): 508 Pierce St.

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-20-1930

17 I HEREBY CERTIFY, That I attended deceased from 4-13- ,1930, to 4-20- ,1930, that I last saw h alive on 4-19- ,1930, and that death occurred, on the date stated above, at 1.45 p.m.

The CAUSE OF DEATH* was as follows: Pulmonary T.B.

History

Personal Knowledge (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Initial Insufficiency (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 516 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carrituck, N. C

DATE OF BURIAL: 4-23 1930

20 UNDERTAKER: Byron Wright 1218 McCulloh St

ADDRESS

TION is very important. See instructions on

APR 23 1930 PEARSON JOHNS M.D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56444

REGISTERED NO. E 56444

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1 PLACE OF DEATH
City of Baltimore: (No.) City Hospital St. 14-20 Ward)

2 FULL NAME Randolph Johnson

(a) RESIDENCE NO. 305 Druid Hill St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed or Divorced. (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown - 1875

7 AGE: Years 55; Months; Days; IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Sandy Johnson

11 BIRTHPLACE OF FATHER (city or town) MD
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant (Address) John Woodard 305 Druid Hill Ave

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocarditis 2 ds.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) C & B Cystitis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas. E. Bradley, M. D.
4-23 1930 (Address) 1430 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

20 UNDERTAKER: Wm. H. Chase Son

DATE OF BURIAL 4-24 1930

ADDRESS 1500 Madison

important. See instructions on back of certificate.

Spec.—1-30—M. & T.—250 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56445

CERTIFICATE OF DEATH.

16 E 56445

REGISTERED NO.

1-PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bezzinia Raphael

(a) RESIDENCE NO. 1636 Thames ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of -

6 DATE OF BIRTH (month, day, and year) 1885 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman on boat.

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Malta

PARENTS

10 NAME OF FATHER Carlo Bezzinia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Malta

12 MAIDEN NAME OF MOTHER Carrie Camino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Malta

14 Informant Records of
(Address) B.C.H.

15 Filed 4-30-1930 C. MAURICE GRIES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-30

17 I HEREBY CERTIFY, That I attended deceased from 4-18-30, 19..., to 4-20-30, 19..., that I last saw him alive on 4-20-30, 19..., and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) General Paralysis of the Insane (duration) over yrs. 2½ mos. ... ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical H.&P.

(Signed) Theron W. Wilson, M. D.

4-24, 19 30 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Hurst Cem.

DATE OF BURIAL 4/23 1930

20 UNDERTAKER John J. Fahey & Sons

ADDRESS 1318 Light St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56446 90 E 56446

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 Rossiter Ave. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Adams

(a) RESIDENCE NO. 524 Rossiter ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 1 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Adams

6 DATE OF BIRTH (month, day, and year) Feb 26 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	77	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward J. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eliza J. Aitcheson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York City

14 Informant Hattie J. Adams

(Address) 524 Rossiter ave

15 Filed Apr 23 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Apr 22, 1930, to Apr 22, 1930,

that I last saw her alive on Apr 22, 1930

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Heart Collapse

1/2 Hour

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Indigestion, 1 Hour

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D.

Apr 23, 1930 (Address) 5106 York Road

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL April 24 1930

20 UNDERTAKER Chas. S. Black — ADDRESS 742 W North ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56447 129 ✓ E 56447

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1145 May ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Jackson

(a) RESIDENCE NO. 1145 May ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): ~~Widowed~~ Married

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: Barrett Jackson

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE — Years: 56 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto MD

PARENTS

10 NAME OF FATHER: Jeremiah Chester

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto MD

12 MAIDEN NAME OF MOTHER: Rebecca Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto MD

14 Informant: Mary Jackson

(Address) 1145 May St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22 1930

17 I HEREBY CERTIFY, That I attended deceased from April 19, 193 . to April 22, 193 .

that I last saw h alive on April 21, 193

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension. Chronic nephritis

(duration) 10 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) S. Feldman M. D.

. 19 (Address) 1430 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pimlico or Pikesville

DATE OF BURIAL: April 23 1930

20 UNDERTAKER: Samuel L. Hemsley

ADDRESS: Eutaw Place

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56448 — 15 E 56448 — 59-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 3225 Old Annapolis Rd ST., (WARD) 25-13

2-FULL NAME Paul Bathum

(a) RESIDENCE NO. 3225 Old Annapolis Rd ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — none

6 DATE OF BIRTH (month, day, and year) April 21 30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edward Bathum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Josephine Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Edw Bathum (Address) Cherrydale Va

15 Filed APR 23 1930 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 23, 1930, that I last saw h[illegible] alive on April 22, 1930, and that death occurred, on the date stated above, at 2 AM.

The CAUSE OF DEATH* was as follows:

Premature Birth
7½ months

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Congenital Malformation of the heart

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Gerhart Kieffer, M. D.

April 23, 1930 (Address) 2454 Kash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL April 23 1930

20 UNDERTAKER Fred A. Klauser & Sons — ADDRESS 703 Hamm

See instructions on back of certificate. IMPORTANT is very important.

Spec.—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56449

CERTIFICATE OF DEATH.

90

E 56449

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1508 Orleans St., 5-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles F. Parr

(a) Residence No. 1508 Orleans St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of): Harriet Parr

6-DATE OF BIRTH (month, day and year)

7-AGE: 70 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Raleigh N. C.

PARENTS

10-NAME OF FATHER: Isham Parr

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Raleigh N. C.

12-MAIDEN NAME OF MOTHER: —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): —

14- (Informant) Harriet Parr

(Address) 1508 Orleans St

15- Filed 1930 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 21-1930

17- I HEREBY CERTIFY, That I attended deceased from April 13 1930 to April 21 1930

that I last saw him alive on April 21 1930

and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas M. D

4-22 1930 (Address) 822 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn Cemetery

DATE OF BURIAL. Apr. 24. 1930

20-UNDERTAKER. Theodore C. White

ADDRESS 3 S. Wolfe St

Spec.—1-30—M. & T.—250 Blks.

E 56450 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56450

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 Mc Culloh ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Grant

(a) RESIDENCE NO. 1130 Mc Culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Grant

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
40	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boot black

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas H Grant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rheuen Upton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Anna Grant (Address) 1130 Mc Culloh

15 Filed APR 23 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21/30

17 I HEREBY CERTIFY, That I attended deceased from Mar 14, 1930, to Apr 21, 1930, that I last saw him alive on Apr 21, 1930, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. D. Hagler, M. D.

4/22, 19 (Address) 1218 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 4-23 1930

20 UNDERTAKER David Carter

ADDRESS 916 Park Ave

Cor.—10-10-29—A Co.—100 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56451

CERTIFICATE OF DEATH

1931 E 56451

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St. 22-30 Ward)

2-FULL NAME Preston Lawson.(C)

(a) RESIDENCE NO. 117 Welcome Al. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Florence, S.C.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Virgie Lovings.(C)
(Address) 117 Welcome Al.

15 Filed ---------- 19 ---------- Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1930 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Internal Hemorrhage due to a pistol shot wound of the abdomen and thigh.
Homicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 115 Welcome Al. April 6, 1930

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Coroners Autopsy & inquest.

(Signed) Geo. M. Leonhardt M. D.

4/22. 1930 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL APR 2 - 1930 19

20 UNDERTAKER

ADDRESS

Deputy Commissioner Health.

APR 2 1930 C. HARRISON JONES, M. D.

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56452

185 E 56452

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital St. 18-29 Ward)

2-FULL NAME Charles Worthington

(a) RESIDENCE NO. No address St., ____ Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., If of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M.	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pattern Maker
(b) General nature of industry, business, or establishment in which employed (or employer) Auto
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Conn.

PARENTS

10 NAME OF FATHER Charles Worthington

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Conn.

12 MAIDEN NAME OF MOTHER Ann Conn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant) Mercy Hospital
(Address) Eutaw & Lee Sts

15 Filed ... 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage - probably due to
hemorrhagic nephritis - of Chronic

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy Conn

(Signed) Harry Conn M. D.

April 19 1930 (Address) 1609 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
PUBLIC CEMETERY Bureau of Health.	ADDRESS
20 UNDERTAKER Per Wm. H. Woodall	

important. See instructions on back of certificate.

APR 21 1930 C. HAMILTON FORD THE REGISTRAR.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56453

101-001 E 56453

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Mary Kirk Ward) St. 4-7 Ward)

2-FULL NAME

(a) RESIDENCE NO. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sailor
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Indiana

PARENTS

10 NAME OF FATHER Peter

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Ann Dunn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mercy Hospital
(Address) Calvert St

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry)
find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Fourdays (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. T. Riley Coroner, M. D.

April 1, 1930 (Address) 16 39 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side foc additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
PUBLIC CEMETERY
Commissioner of Health

20 UNDERTAKER
Wm E. Woodall

DATE OF BURIAL
19

ADDRESS

Important. See instructions on back of certificate.

Spec.—8-16-29—L. F. S.—100 Bks.

2 3 E 56454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ 1-0 E 56454

+ 154

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dean Mercer

(a) RESIDENCE NO. Norfolk - 2a - ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May-3-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11½	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va -

PARENTS

10 NAME OF FATHER Harry Mercer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Susan Mayhew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va -

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. H. EMPSON, JOHNS H. [illegible] 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23-30

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1930, to April 23, 1930, that I last saw her alive on April 23, 1930 and that death occurred, on the date stated above, at 11.50 a m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus congenital

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? yes Date of 12-IV 30

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) H. Longbrake Jr, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va	Apr 23 1930
20 UNDERTAKER John O Mitchell & Son	ADDRESS 1918 Eutaw

Spec.—2-29-28—L. F. S.—500 Bks. Vit 6370

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56455

CERTIFICATE OF DEATH

49 E 56455

1—PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette & Calhoun Sts. 21-29 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. William Kelbaugh

(a) RESIDENCE NO. 1166 Sargent St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E

6 DATE OF BIRTH (month, day, and year) Nov 12, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henderson Kelbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Margaret E Kelbaugh
(Address) 1166 Sargent St.

15 Filed APR 23 1930 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 12 1930, to April 22, 1930, that I last saw h[illegible] alive on April 22, 1930 and that death occurred, on the date stated above, at 11:10 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Terminal Hypostatic Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal puncture

(Signed) M. S. Schreiber, M. D.

19 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 24 1930

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

78 E 56456

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 310 Bethel Court St. 4-7 Ward)

2-FULL NAME Stephen Roy

(a) RESIDENCE NO. 310 Bethel Court St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER W. Roy

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER M. Lee

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant D. Riggs Boyds Md
(Address)

15 Filed ... 19 ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22, 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

Infancy (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Phelps, M. D.

Apr 23 1930 (Address) 639 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boyds Md

DATE OF BURIAL Apr 25 1930

20 UNDERTAKER E. E. Gartner

ADDRESS Hawthorne Md

important. See instructions on back of certificate.

23 1930

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56457

CERTIFICATE OF DEATH

90 E 56457

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Cambridge Arms Apts. ST. 5 C WARD) 12-49

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara Belle Heinicker

(a) RESIDENCE NO. Cambridge Arms Apts. ST. 5 C WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Late Harry S. Heinicker

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Coggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Martha Ann Denny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Frank V. Coggins

(Address) ~~4 J Cambridge Arms Apts.~~

15 Filed C. HAMPSON JONES, M. D. 2 3 1930 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1930, to April 22, 1930, that I last saw her alive on April 21, 1930 and that death occurred, on the date stated above, at 3-30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus (Right Hemiplegia) Auriculer Fibrillation, Mitral Stenosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M. Tilton Porter, M. D.

4/23, 1930 (Address) 4822 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: 4/25/30,

20 UNDERTAKER: Harry S. Nuttle, 410

ADDRESS Edmondson Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56458 ✓ E 56458

E 56458

CERTIFICATE OF DEATH

× 49

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Sinclair

(a) RESIDENCE NO. 1909 N Payson ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 4 yrs. 4 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 30 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none (child)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey.

PARENTS

10 NAME OF FATHER Thomas Sinclair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hattie West

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant father & friend.

(Address) same

15 Filed 4 23 1930, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23. 1930

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1930, to April 23, 1930

that I last saw h/ alive on April 23, 1930

and that death occurred, on the date stated above, at 1:15 P.m.

The CAUSE OF DEATH* was as follows:

Sarcoma of kidney right and adrenal gland, right

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of April 23 1930

Was there an autopsy? no

What test confirmed diagnosis? Pathological examination

(Signed) W. Edward Zoeller, M. D.

4/23, 1930 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem

DATE OF BURIAL 4/25/30

20 UNDERTAKER Harry A. Fitzke

ADDRESS 4[illegible] Edmondson Ave

Spec.—1-30—M. & T.—250 Bks.

E 56459 HEALTH DEPARTMENT—CITY OF BALTIMORE E 56459

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 624 S. Payson ST. 20-28 (WARD)

2-FULL NAME Melvin Lee Morrissett

(a) RESIDENCE NO. 624 S. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 5th, 1918

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
12	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER H. H. Morrissett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Susie M. Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant H. H. Morrissett

(Address) 624 S. Payson Street

15 Filed 3 1930, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1930, to April 22, 1930,

that I last saw him alive on April 22, 1930,

and that death occurred, on the date stated above, at 10.35 A. M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

Myocarditis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Hamilton Smith, M. D.

4/23/30 (Address) 257 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 19..

ADDRESS

20 UNDERTAKER F. B. Wippert, 1850 W. Baltimore St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 56460

REGISTERED NO. E 56460

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3035 McElderry St., 7-11 Ward)

2-FULL NAME Walter Woolford

(a) RESIDENCE NO. 3035 McElderry St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Virginia Woolford

6 DATE OF BIRTH (month, day, and year) March 1/1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	56	1	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Capt. Ice Boat
(b) General nature of industry, business, or establishment in which employed (or employer) Annapolis
(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Woolford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER Eliza Bell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dorchester Co. Md.

14 Informant Virginia Woolford
(Address) 3035 McElderry St

15 Filed ——— 19 ——— C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22/30

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Report of Angina

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Hatem, M. D.

4/23/30 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore C. Cem.	April 25 1930
20 UNDERTAKER Wm. C. Miller & Son	ADDRESS 2331 Maryland Ave

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

APR 23 1930

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56461

CERTIFICATE OF DEATH

97-002 E 56461

REGISTERED NO. 6-68

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward E. Harr

(a) RESIDENCE NO. 2828 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Paul M. Harr.

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1901.

7 AGE	Years	Months	Days.	If LESS than 1 day, ...hrs. or ....min.
	28	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Police Dept.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas L. Harr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eva M. Sadler.

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D.C.

14 Informant Paul M. Harr

(Address) 2828 W. Lanvale St

15 Filed APR 3 1930 19 C. HAMILTON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22/30

17 I HEREBY CERTIFY, That I attended deceased from 4/19, 1930, to 4/22, 1930,

that I last saw him alive on 4/22, 1930

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, Staphylococcic

(duration) yrs. mos. 3-4 ds.

CONTRIBUTORY (Secondary) Sinusitis, acute, frontal

(duration) yrs. mos. , ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Symptoms

(Signed) Jos. E. Stacy Jr. M. D.

4/22, 1930 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	4/25, 1930
20 UNDERTAKER	ADDRESS
H. Hutchinson	330 Fremont St

IMPORTANT. SEE INSTRUCTIONS ON REVERSE SIDE.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 56462

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 56462

1-PLACE OF DEATH
City of Baltimore: (No. Mercy Hospital 13-57 St., Ward)

2-FULL NAME George Hollinger

(a) RESIDENCE NO. Buena Vista Ave 3636 St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Div.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3-1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	32	10	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Frank Hollinger

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unk Va

14 Informant Era G. Hollinger
(Address) 3636 Buena Vista Ave

15 Filed ....., 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec. 22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Depressed Fracture of Skull Caused by injuries sustained accidentally by Fall of board

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of
Was there an autopsy? no
What test confirmed diagnosis? —
(Signed) W. T. Riley Conner, M. D.
12.23 1930 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cemetery — DATE OF BURIAL 12/25/1930

20 UNDERTAKER Walter Davis — ADDRESS 3307 Pierce

OF DEATH in plain terms, so that it may be properly classified. Exact statement of the cause is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56463

REGISTERED NO. E 56463

1-PLACE OF DEATH

City of Baltimore: (No. 318 S Bond Mercy Hospital St. 3rd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Mary

(a) RESIDENCE NO. 318 S Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) June 12. 1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	10	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Georgia
(State or country)

PARENTS

10 NAME OF FATHER Patrick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ga.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mercy Hospital
(Address) Calvert & 22nd Sts

15 Filed ..... 19.. ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism
accidental

(duration) yrs. mos. ds.

Opinion

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Phelan Corner, M. D.

Apr 21, 1930 (Address) 1034 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Trinity Indpd Sem. Govt

DATE OF BURIAL 19 30

20 UNDERTAKER Wendell J Lippel

ADDRESS 301 N Calvert

OF DEATH in plain terms, so that it may be properly classified. Last statement of cause important. See instructions on back of certificate.

Spec.—8-15-29—L. F. S.—100 Bks.

28630 E 56464

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 56464

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mildred Nixon

(a) RESIDENCE NO. 1190 E. Lanvale ST. St - WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/23/29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Winstead Nixon

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C -

12 MAIDEN NAME OF MOTHER Leslie Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C -

14 Informant Friends -

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22-30

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1930, to April 22, 1930, that I last saw her alive on April 22 1930 and that death occurred, on the date stated above, at 7 45 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) otitis media

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy + physical exam.

(Signed) J W Bickford, M. D.

4/22/1930 (Address) JHH.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL April 24 1930

20 UNDERTAKER Edward Bryan

ADDRESS 1691 Orleans St

APR 24 1930 C. HAMILTON JONES, M. D.

Registrar

For

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56465

REGISTERED NO. E 56465

1—PLACE OF DEATH E 56465

CITY OF BALTIMORE: (No. 927 Plum St. WARD) 23-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Fisher

(a) RESIDENCE NO. 927 Plum St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 3 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Fisher

6 DATE OF BIRTH (month, day, and year) Dec-31-1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sawyer Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sundell Bros.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William Fisher

11 BIRTHPLACE OF FATHER (city or town) Eastern Shore (State or country) Virginia

12 MAIDEN NAME OF MOTHER Rose Hester

13 BIRTHPLACE OF MOTHER (city or town) Eastern Shore (State or country) Virginia

14 Informant Rose Fisher

(Address) 927 Plum St.

15 Filed [illegible], 19 [illegible] Registrar

C. HAMPSON JONES, M. D.

APR 24 1930

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/21/30

17 I HEREBY CERTIFY, That I attended deceased from 2/17, 1930, to 4/21, 1930, that I last saw h[illegible] alive on 4/21, 1930 and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum Exam

(Signed) Wm Francis M. D.

4/21, 1930 (Address) 122 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 4-25 1930

20 UNDERTAKER John H. Trader

ADDRESS 1027 Hanover

Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56466

E5-6466

74-001 E 56466

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1011 Plum Alley 23-31 Ward)

2-FULL NAME Albert Lee

(a) RESIDENCE NO. 1011 Plum alley Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie Lee

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	38	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber bus.

(c) Name of employer J. W. Hooper

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Arnold Lee

11 BIRTHPLACE OF FATHER (city or town) Annapolis

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Brown

13 BIRTHPLACE OF MOTHER (city or town) A. A. Co.

(State or country) Md.

14 Informant Robt. Lee

(Address) 916 Sharp St.

15 Filed APR 24 1930 Registrar

OF DEATH in plain terms, so that it may be properly classified. Certificates, very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 21 1935 19

17 I HEREBY CERTIFY, That I attended deceased from Apr 20 1930 to Apr 22 1930, that I last saw h~~im~~ alive on Apr 22 1930 and that death occurred, on the date stated above, at 10.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) arterial hypertension

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) H. H. Thrasher M. D.

4/23/30 (Address) 830 Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn	4-24 1930
20 UNDERTAKER John H Tradum	ADDRESS 1027 Druid Hill

Spec.—6-16-29—L. F. S.—100 Bks.

236003 E 56467

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 56467

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 70-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Dolan

(a) RESIDENCE NO. 1314 Clinton ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July-9-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katharine Starr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-21-1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to April 21, 1930, that I last saw her alive on April 21, 1930, and that death occurred, on the date stated above, at 11 30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic valvular heart disease (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J W Bickford, M. D.

4/22/1930 (Address) JHH

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Apr. 25, 30.

20 UNDERTAKER: Lilly & Zeiler, Inc. — ADDRESS: 403 S. Wolfe St.

Important: Use blue or black ink only.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56468

CERTIFICATE OF DEATH

E 56468

1—PLACE OF DEATH
CITY OF BALTIMORE (No. South Baltimore Gen'l Hospital ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary E. Pleines

(a) RESIDENCE NO. (Usual place of abode) 133 N. Streeper ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Charles Pleines

6 DATE OF BIRTH (month, day, and year) [illegible] 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	49	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Yaeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Carroll Son
(Address) 133 N. Streeper St.

15 Filed APR 24 1930 HARRISON JONES M Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-30

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1930, to 4-20, 1930, that I last saw her alive on 4-20, 1930 and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver with Metastases (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3/27/30

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Joseph V. Baukaitis, M. D.

19 (Address) South Balto. Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL April 25 1930

20 UNDERTAKER D. Kelly & Son Inc.

ADDRESS 733 S. Monroe St

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56469

CERTIFICATE OF DEATH

111-601 E 56469

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caulkins Alley St. 16-22 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Frazier

(a) RESIDENCE NO. 413 Morris St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE: Years 44; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Sallie Frazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eugene Frazier
(Address) 413 Morris St

15 Filed APR 24 1930 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1930

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1930, to April 22, 1930

that I last saw he alive on April 22, 1930

and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of April 17, 1930

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O'Meara, M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL 4/24 19 30

20 UNDERTAKER Samuel L. Hensley

ADDRESS 1178 Edmondson

CAUSE OF DEATH: In plain terms, state the disease, if any, directly causing death, and the primary cause, if any, giving rise to it. See instructions on back of certificates.

Spec. 130 M A T. 250 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 56470 — REGISTERED NO. E 56470

1. PLACE OF DEATH: Baltimore City Hospitals — WARD 11-24

CITY OF BALTIMORE: (NO. ..... ST. ..... WARD .....)

2. FULL NAME: Frank Billups

(a) RESIDENCE NO. 1125 Pennsylvania Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Henry Billups

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Records of B. C. H.

15 Filed APR 24 1930 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-21-30

17 I HEREBY CERTIFY, That I attended deceased from 4-17-30, 19..., to 4-21-30, 19...,
that I last saw him alive on 4-21-30, 19...,
and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:
Myocarditis, chronic Acute

(duration) ... yrs. 1 mos. ? ... ds.

CONTRIBUTORY (Secondary): Hypertension (duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Clinical
(Signed) Harrison Wilkerson, M. D.
4-22 1930 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn Cem.

DATE OF BURIAL: April 24, 1930

UNDERTAKER: John H. Cowen

ADDRESS: 5934 Belair Rd

Spec.—1-30—M. & T.—250 Bks.

E 56471 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 56471

CERTIFICATE OF DEATH.

REGISTERED NO.

1. PLACE OF DEATH BALTIMORE CITY HOSPITALS (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 18-76 ST. WARD)

2. FULL NAME Hannah Dutton,

(a) RESIDENCE NO. 532 N. Carrollton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1856?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74?	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Nicholas Dutton.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records
(Address) BALTIMORE CITY HOSPITALS

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1930.

17 I HEREBY CERTIFY, That I attended deceased from May 2 1928 to April 20 1930, that I last saw her alive on April 20 1930, and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Abscess of Brain 7

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Myocarditis, chronic

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? In hospital 2. Home.

Did an operation precede death? No Date of -

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Paul Padget, M. D.

3. 22. 1930 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL Apr. 24 30

ADDRESS 1302 Jeffers

20 UNDERTAKER Mrs J. G. Locke

Spec.—1-30—M. & T.—250 Bks.

E 56472 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 56472

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. Sinai Hospital ST. 27-41 WARD)
2. FULL NAME Dolores Mitchell
(a) RESIDENCE NO. 4115 Mary Ann ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	child

5a If married, widowed, or divorced (or) HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	8	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS
10 NAME OF FATHER Joseph Mitchell
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto
12 MAIDEN NAME OF MOTHER Josphine Ustasinek
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Joseph Mitchell
(Address) 4115 Mary Ann Ave

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1930

17 I HEREBY CERTIFY, That I attended deceased from April 20 .19 30. to April 21 .19 30.
that I last saw her alive on April 21 .19 30.
and that death occurred, on the date stated above, at 1 30 p m.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? phys signs & xray
(Signed) J H Conn M. D.
(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL April 24 1930

20 UNDERTAKER Frank V. Pipitone — ADDRESS 251 E. Balto st

R 24 1930

Cor.—10-10-29—A Co.—100 Bks.

E 56473

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 VE 56473

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3004 Auchentoroly Ter. Ward 59)

2-FULL NAME Katherine Virginia Montell

(a) RESIDENCE NO. 3004 Auchentoroly Ter Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of James E. Montell

6 DATE OF BIRTH (month, day, and year) 1852?

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Housework
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Pa

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) unknown

14 Informant James E. Montell
(Address) 3004 Auchentoroly Ter

Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1930

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (autopsy or inquiry) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John F. Morrissey M. D.

4/23 1930 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	April 24th 1930
20 UNDERTAKER Henry K. Jenkins Sons Co	ADDRESS McCulloh & Orchard St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 56474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 56474

REGISTERED NO. 12-5129

1—PLACE OF DEATH
CITY OF BALTIMORE (No.) South Baltimore General Hospital (ST.) (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Ella Birch Eversfield

(a) RESIDENCE NO. St. Paul Court Apts. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): widowed

6 DATE OF BIRTH (month, day, and year) Oct 22 1856

7 AGE: Years 73 | Months 6 | Days 1 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: not any
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Bersch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary E. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. H. Eversfield
(Address) St. Paul Court Apts

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-23-30

17 I HEREBY CERTIFY, That I attended deceased from 4-17, 1930, to 4-23, 1930 that I last saw her alive on 4-23, 1930 and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Cardio-vascular Renal Disease (duration) 15 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? Physical Findings

(Signed) Dr. Hugh Y. Hamilton, M. D.

... 19 (Address) South Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL: Apr 26 19 30

20 UNDERTAKER: Chas. H. Thompson Jones | ADDRESS: Eutaw Place

Important. See instructions on back of this sheet.

APR 24 1930

Spec.—1-30—M. & T.—250 Bks.

E 56475

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 56475

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3034 Cold Spring Ave. St.) (27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josef Kondler

(a) RESIDENCE No. 3034 Cold Spring Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna E. Kondler

6 DATE OF BIRTH (month, day, and year) Mar. 18, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dock Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Sugar Refinery

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Matthews Kondler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Johanna Kondler

(Address) 3034 Cold Spring Ave.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 22 1930

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1930, to April 22, 1930,

that I last saw h alive on April 22, 1930,

and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. — mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) C. W. Swan for C. B. M. D.

4-25, 1930 (Address) 4936 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Apl. 25 1930

20 UNDERTAKER Wm Mickner Sons. — ADDRESS North & Pa

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 12th DAY July

OF 1965 THE MICROPHOTOGRAPHS APPEARING

HEREIN STARTING WITH #E53001- JAN 15 1930 AND

ENDING WITH #56475- APR 24 1930 ARE AC-

CURATE AND COMPLETE REPRODUCTIONS OF THE

RECORDS OF THE DEPARTMENT OF Health

BUREAU OF Vital Statistics AS DELIVERED

IN THE REGULAR COURSE OF BUSINESS FOR

PHOTOGRAPHING, AND THAT:

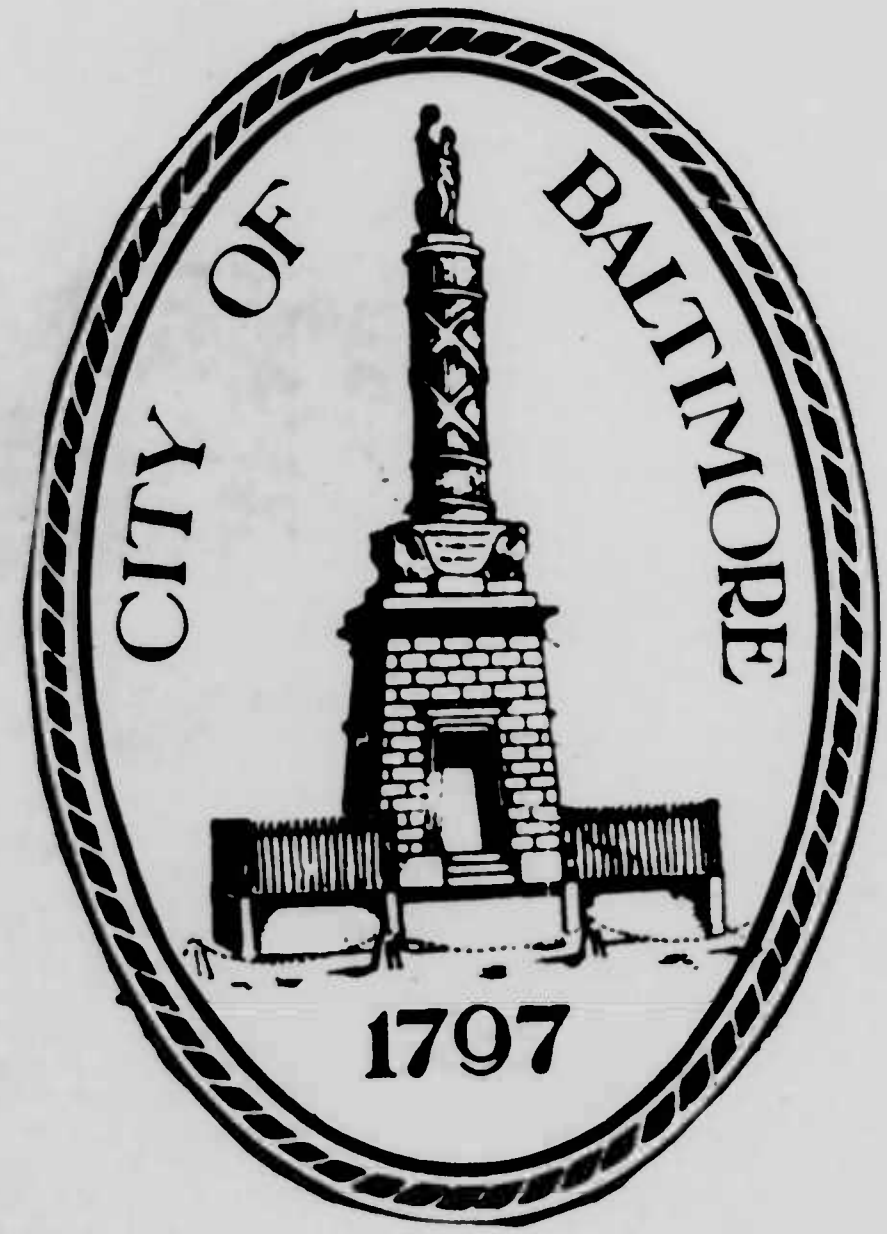
TO THE BEST OF MY KNOWLEDGE THE MICROFILM

MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU

OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC

COPY.

CAMERA OPERATOR: D. McFaul



END OF REEL